NCIN
national cancer intelligence network
Using information to improve quality & choice

CANCER OUTCOMES AND SERVICES DATASET (COSD)

User Guide

Version 2.1

VERSION CONTROL

Version	Date	Brief Summary of Change	Editor
Draft 0.1	15.08.2011	Initial draft version produced	Trish Stokes/Shaun Gallagher
Draft 0.2	15.09.2011	Updated following circulation to SSCRG Chairs	Trish Stokes/Shaun Gallagher
Version 1.0	22.09.2011	Finalised for operational testing	Trish Stokes/Shaun Gallagher
Version 1.1	15.12.2011	Updated to include feedback from operational testing	Trish Stokes/Shaun Gallagher
Version 1.2	19.01.2012	Amendments made	Trish Stokes/Shaun Gallagher
Version 1.3	01.02.2012	Amendments made	Trish Stokes/Shaun Gallagher
Version 1.4	23.02.2012	Updated with finalised COSD version 0.5.0	Trish Stokes/Shaun Gallagher
Version 1.5	24.02.2012	Finalised for draft ISB submission	Trish Stokes/Shaun Gallagher
Version 1.6	18.04.2012	Updated for full stage ISB submission	Trish Stokes/Shaun Gallagher
Version 1.7	11.05.2012	Updated post ISB submission. Frozen for further consultation.	Trish Stokes/Shaun Gallagher
Version 1.8	01.06.2012	Minor amendments, specifically the inclusion of the SERVICE REPORT IDENTIFER data item to align with version 0.5.2 of the COSD. Submitted to ISB for full stage submission Board.	Trish Stokes/Shaun Gallagher
Version 1.9	20.07.2012	Haematology codes list updated. Additional minor amendments. User Guide published on the NCIN website.	Trish Stokes/Shaun Gallagher
Version 2.0	18.01.2013	Update to ICD10 table to include 4th Edition amendments and clarification of the Dataset required for each disease. Updated Haematology table to include further amendments to ICDO3 codes and additional coding levels for specific morphologies. General guidance on the expected staging system by tumour type. Amended to include changes identified in version 1.1 of the COSD. Correction to a number of minor errors identified.	Trish Stokes/Shaun Gallagher

Version 2.1	23.10.2013	Updated to include a number of COSD data changes. See 'What's updated since version 2.0' below for further information.	Trish Stokes/Shaun Gallagher

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STATUS – USER GUIDE

Information for Implementation Stage – Phase 3 – Changes to dataset from April 2014

This User Guide version 2.1 is one of a suite of documents to aid Users in implementing the COSD Information Standard (ISN# ISB 1521) which was mandated from January 2013. It includes all the data items in COSD, together with definitions, formats, codes and values and additional guidance on collection and implementation.

This revised version of the User Guide includes further guidance and some minor changes which have been identified during implementation. It is aligned with, and should be read in conjunction with version v1.2 of the dataset which is available to download on the NCIN website. Other guidance and support documents, including FAQ, are also available on the NCIN website and we are continuing with plans to provide an online version of the Guide.

Phase 3 of implementation includes the submission of the site specific pathology items from January 2014 from which time the full dataset should be submitted. In addition to this a small number of revisions included here will take effect from April 2014. The formal change notice to support these changes is due to be published in December 2013.

Implementation of the Standard is being carried out by the National Cancer Registration Service (NCRS) and queries regarding implementation should initially be raised with the Data Liaison staff at the local offices of the NCRS.

We are very pleased to report that by the beginning of October 2013 all but one Provider was submitting COSD data and only three Providers had failed to sign and return a Data Transfer Partnership Agreement, describing the files to be submitted.

All Providers have access to their current monthly position via the national COSD Conformance Monitoring Feedback Portal which has been established by the NCRS. This currently provides feedback on files submitted and completion for some key data items where the files are submitted in the prescribed XML format.

Level 3 reports based upon post-registered data have not been delivered as expected due to a range of issues of which the most significant has been the delays in migrating all legacy systems and normalising 11 million patient records on the national ENCORE platform. This has been more complex and taken much longer than could have been anticipated but is now completed. This has however provided the opportunity to review and improve the initial specification and the revised Level 3 reports are expected to be available during the first quarter of 2014.

We would like to take this opportunity to thank all those who have been involved in the development and implementation of the Standard and encourage you to continue to send us your comments which help to identify necessary amendments and improvements.

Trish Stokes, Datasets Programme Manager, NCIN

October 2013

WHATS CHANGED SINCE VERSION 2.0

Below notes the significant changes that have occurred since the last version of the User Guide.

CORE

Change data item name and description, to clarify the point in the pathway when these items are recorded. These changes affect:

- CONSULTANT CODE (FIRST SEEN) (Core dataset / CR0210)
- CARE PROFESSIONAL MAIN SPECIALTY CODE (FIRST SEEN) (Core dataset / CR0220)
- CONSULTANT CODE (TREATMENT) (Core dataset / CR0660)
- CARE PROFESSIONAL MAIN SPECIALTY CODE (TREATMENT) (Core dataset / CR0670)

Change data item format to allow recording to 2 decimal places (max nX.max n2) in order to standardise measurement items and enable a greater degree of accuracy where applicable. This change affects:

- LESION SIZE (RADIOLOGICAL) *(Core dataset / CR0350)*
- LESION SIZE (PATHOLOGICAL) *(Core dataset / CR0830)*

Additional value 'Other' in order to enable new, unlisted types of treatment to be captured. This change affects:

- CANCER CLINICAL TRIAL TREATMENT TYPE *(Core dataset / CR1260)*

Addition of the following new data items to pilot the feasibility and potential benefits of using SNOMED CT and to support the National Information Strategy (These are only applicable for those taking part in the pilot study):

- MORPHOLOGY (SNOMED CT) *(Core dataset / CR3030)*
- PRIMARY PROCEDURE (SNOMED CT) (*Core dataset / CR3040)*
- PROCEDURE (SNOMED CT) *(Core dataset / CR3050)*
- TOPOGRAPHY (SNOMED CT) *(Core dataset / CR3060)*
- MORPHOLOGY (SNOMED CT) *(Core dataset / CR3070)*

Addition of the following two new data items, and subsequent removal of ORGANISATION CODE (RESPONSIBLE PCT), in order to reflect changes in organisational structure to Clinical Commissioning Groups (CCGs). Neither of these data items would be submitted by Providers.

- ORGANISATION CODE (GP PRACTICE RESPONSIBILITY) *(Reference Other Sources / CR3080)*
- ORGANISATION CODE (RESIDENCE RESPONSIBILITY) *(Reference Other Sources (CR3090)*

BREAST

Change data item format to allow recording to 2 decimal places (max nX.max n2) in order to standardise measurement items and enable a greater degree of accuracy where applicable. This change affects:

- NON INVASIVE TUMOUR SIZE *(Breast dataset / BR4180)*
- WHOLE TUMOUR SIZE *(Breast dataset / BR4190)*

CNS

Change data item format to allow recording to 2 decimal places (max nX.max n2) in order to standardise measurement items and enable a greater degree of accuracy where applicable. This change affects:

- LESION SIZE (RADIOLOGICAL) *(CNS dataset / BA3030)*

COLORECTAL

Change data item format to allow recording to 2 decimal places (max nX.max n2) in order to standardise measurement items and enable a greater degree of accuracy where applicable. This change affects:

- DISTANCE TO CIRCUMFERENTIAL MARGIN (*Colorectal dataset / CO5210)*
- DISTANCE BETWEEN LOWER END OF TUMOUR AND DISTAL RESECTION MARGIN *(Colorectal dataset / CO5230)*
- DISTANCE FROM DENTATE LINE *(Colorectal dataset / CO5270)*
- DISTANCE BEYOND MUSCULARIS PROPRIA *(Colorectal dataset / CO5280)*
- DISTANCE TO CIRCUMFERENTIAL EXCISION MARGIN *(Colorectal dataset / CO5310)*

Change in data item format to max n4.max n2 in order to align to clinical practice. This change affects:

- DISTANCE BETWEEN LOWER END OF TUMOUR AND DISTAL RESECTION MARGIN *(Colorectal dataset / CO5230)*

Data item currently suspended due to it being a duplicate of DISTANCE TO CIRCUMFERENTIAL MARGIN (CO5210). This suspension affects:

- DISTANCE TO CIRCUMFERENTIAL EXCISION MARGIN (Colorectal dataset / CO5310)

CTYA

Change data item format to allow recording to 2 decimal places (max nX.max n2) in order to standardise measurement items and enable a greater degree of accuracy where applicable. This change affects:

- PRIMARY TUMOUR SIZE (RADIOLOGICAL) *(CTYA dataset / CT6400)*

GYNAECOLOGY

Change data item format to allow recording to 2 decimal places (max nX.max n2) in order to standardise measurement items and enable a greater degree of accuracy where applicable. This change affects:

- INVASIVE THICKNESS *(Gynaecology dataset / GY7330)*
- THICKNESS UNINVOLVED STROMA *(Gynaecology dataset / GY7360)*
- INVASIVE THICKNESS *(Gynaecology dataset / GY7390)*

HAEMATOLOGY

Change data item name, description, format and national code due to a change in clinical practice whereby this is now measured in g/l, rather than g/dl, in haematology laboratories. This change in measurement means a change in format to max n3 and a range of 10 – 250. This change affects:

- BLOOD HAEMOGLOBIN CONCENTRATION (GRAMS PER LITRE) *(Haematology dataset / HA8100)*

Change data item description in order to take into account the above mentioned change in blood haemoglobin concentration. This change affects:

- IPSS (MYELODYSPLASIA) *(Haematology dataset / HA8080)*
- RAI STAGE *(Haematology dataset / HA8230)*
- BINET STAGE *(Haematology dataset / HA8240)*
- FLIPI INDEX SCORE *(Haematology dataset / HA8360)*
- HASENCLEVER INDEX *(Haematology dataset / HA8670)*

SARCOMA

Addition of the following new data item which is a component required for staging Gastrointestinal Stromal Tumours (GISTs):

- MITOTIC RATE (SARCOMA) *(Sarcoma dataset / SA11220)*

SKIN

Change data item format to allow recording to 2 decimal places (max nX.max n2) in order to standardise measurement items and enable a greater degree of accuracy where applicable. This change affects:

- FINAL EXCISION MARGIN AFTER WIDE LOCAL EXCISION *(Skin dataset / SK12450)*

Change data item format from max n2 to max n3 and remove range restriction in order to capture actual value recorded. Change of data item name to MITOTIC RATE (SKIN) in order to differentiate it from item in the Sarcoma dataset. These changes affect:

- MITOTIC RATE (Skin dataset / SK12590)

UPPER GI

Deletion of value 'Cardia' (11 - national code) as it is no longer used. This change affects:

- POST OPERATIVE TUMOUR SITE (UPPER GI) *(Upper GI dataset / UG14230)*

APPENDIX A

- Missing D codes (D05.0, D05.1, D05.7 and D05.9) added to Cancer Waiting Times ICD10 Codes and Tumour Groups for Primary Diagnoses

APPENDIX B

Although Primary amyloidosis (E85.9) is listed as an E ICD code in the World Health Organisation (WHO) disease classification, amongst clinicians it is widely acknowledged and subsequently treated as a cancer, receiving Chemotherapy in cases. Whilst we await the WHO disease classification being updated to reflect this fact, we are proposing extending the scope of the COSD to include this. The United Kingdom and Ireland Association of Cancer Registries (UKIACR) is currently considering its inclusion in the UKIACR Library of Recommendations.

INTRODUCTION

What is the Cancer Outcomes and Services Dataset?

The Cancer Outcomes and Services Dataset (COSD) is the new national standard for reporting cancer in the NHS in England. It replaces the National Cancer Dataset and the Cancer Registration Dataset and includes additional site specific data items relevant to the different tumour types. It is aligned with other national cancer datasets, including Cancer Waits (NCWTMDS), Radiotherapy (RTDS), Systemic Anti Cancer Therapy (SACT) and Diagnostic Imaging (DID).

Why is it needed?

We needed to revise the National Cancer Dataset to ensure that we meet the current information requirements for the NHS. The Cancer Reform Strategy (2007) identified better information and stronger commissioning as two of the key drivers to achieve the goal that cancer services in this country should be amongst the best in the world. The subsequent Improving Outcomes: A Strategy for Cancer (January 2011) further supports this concept to demonstrate cancer outcomes using high quality data and intelligence for all stakeholders.

What is different from previous data collection?

The COSD clarifies the data items that need to be submitted electronically directly to the National Cancer Registration Service on a monthly basis. Most Providers have been sending monthly data submissions directly to the registries from systems such as MDT (Multi-disciplinary Team) software, PAS (Patient Administration Systems) and Pathology. The COSD includes updated definitions and values for these items. Many other items in the COSD are already submitted through standard NHS routes such as Cancer Waits and, apart from key items, these do not need to be resent. Most of the remaining items in the COSD are site specific and are required for patient management and clinical care. These also need to be submitted directly to the registries. The data which Providers send to the registries directly may be submitted in separate files from different Provider systems although most of the data items are likely to be extracted from MDT software systems. Data from all sources will be linked by the registries at patient level using NHS Number to complete the full dataset.

This User Guide contains all data items which need to be included in the monthly submission by NHS Providers of Cancer Services to the National Cancer Registration Service. The Guide provides a description of the data items, the tumour sites or disease types to which they apply and any further information needed to collect them.

Other guidance documentation

Technical Guidance and Implementation Guidance is provided separately.

Which diagnoses does COSD apply to?

The COSD is applicable to all UK Association of Cancer Registries (UKACR) registerable conditions (see Appendix B). It relates to all new diagnoses from 1st January 2013. For the purposes of COSD the term “cancer” is used throughout the documentation to apply to all these registerable conditions.

What data items should be completed?

All registerable conditions should be reported as defined in Appendices A and B. This includes submitting all pathology reports for these cases.

For some high volume diseases, generally those which do not require MDT discussion, only pathology reports are required and no other information needs to be submitted for COSD.

For all other cases as a minimum the core dataset should be completed, including all applicable data items.

In addition to the core dataset, most cases will also require a site specific dataset to be completed.

For under 25s, there may be two "site specific" datasets completed (CTYA and disease specific), depending on the nature of the disease and where the patient is treated. Please see CTYA section 5.1 of this Guide for further details.

Appendices A and B provide further details by tumour type.

PLEASE NOTE ALL ITEMS IN THE DATASET (except those marked "X" in the schema specification and those in the greyed out sections of the COSD Dataset) ARE MANDATORY WHERE APPLICABLE UNLESS STATED OTHERWISE IN THE DESCRIPTIONS. THIS INCLUDES ALL ITEMS MARKED AS BOTH 'MANDATORY' (M) AND 'REQUIRED' (R) IN THE SCHEMA SPECIFICATION.

The Dataset is divided into Sections (e.g. CORE – IMAGING, LUNG PATHOLOGY etc.) and for each record a section can only be submitted if the Mandatory items in that section are completed.

Items marked as "X" in the schema specification should not be submitted as part of the COSD data flow from Providers. These items will be collected from other sources such as ONS (See Appendix L) or are submitted under other standards such as Cancer Waiting Times and RTDS (See Appendix K). Items that are shared specifically with the Cancer Waiting Times dataset (NCWTMDS) are marked as (CWT) in the relevant descriptions. However for COSD these items are all extended to relate to all registerable conditions. Definitions within these items for "primary cancer" are therefore also extended to cover all registerable conditions.

When should the data be submitted

The deadline for first submitting a record is 25 working days after the end of month of Diagnosis. All available relevant data items should be included and additional information or updates not available at the time should be uploaded with ensuing monthly submissions. Treatments not submitted with the initial record should also be submitted within 25 working days of the end of month of the Treatment Start Date. See Appendix H for further details.

Phased Implementation

The dataset is mandated for phased submission from January 2013. The core and site specific stage should be completed for **all** relevant cases from that date. All other site specific clinical data (i.e. all site specific data excluding site specific pathology sections) should be completed from July 2013. The remaining site specific pathology sections should be completed from January 2014. (See Appendix G and COSD Specification for further details)

Online Training

A free online training course aimed primarily at non clinical staff is available to support those involved in collecting the data. See Appendix M for further details

Feedback and Queries

Feedback and questions relating to the COSD are welcomed and should be emailed to:

cosd@ncin.org.uk

The COSD Project Team would like to express their thanks to all those who have participated and continue to provide support and guidance in the development of this information standard.

Trish Stokes, COSD Programme Manager, NCIN

0. USING THIS GUIDE

This User Guide provides additional information to support the COSD Specification and should also be used in conjunction with the COSD Dataset. Implementation and Technical Guidance documents are also available for further information on the NCIN website.

0.1 Layout of the User Guide

The COSD Dataset and User Guide are structured to reflect the patient pathway. Each of the core and site specific datasets is divided into sections along the pathway. Each of these sections contains the data items relevant to that section and these data items are likely to be collected at that point in the pathway.

The Guide includes a Generic chapter for Core dataset followed by individual chapters for each of the site specific datasets applicable to each Tumour Group.

Each chapter is laid out similarly, and arranged as follows:

- **Overview**
- **ICD-10 codes for the Tumour Group**
- **Sections as per the COSD Dataset, each including**
  - **Table of data items**
  - **Details of the data items - description, codes and values**

MEANING OF "NOT KNOWN" VALUE

"Not known" includes both "not recorded" and for example "test not done". This is usually coded 9 or 99 (depending on the data item format).

LIST OF REGISTERABLE DISEASES

The ICD10 disease codes lists for all registerable conditions (C & D codes) are provided in Appendices A and B. The Haematology ICDO3 codes list can be found in Section 7.2 ICD CODES AND WHO DISEASE GROUPS.

0.2 Key to Data Item Tables

All data items are listed as follows

Data item No.	The reference number for the COSD data item
Data Item Section	The section in which the data item appears
Data Item Name	The name of the data item. This is followed by the *[DATA DICTIONARY ITEM NAME]* if different
Format	Format required for submission of the data item
Schema specification (M/R/O/X/P)	The detailed schema for submission of the data is included in the Technical Guidance. This column identifies whether items are required for the extract to pass validation rules when submitted in XML format. (Note that all applicable data should be submitted as soon as possible) M = Mandatory: A section cannot be included in the record submitted unless it contains completed Mandatory items in that section. If there is other data in a section and the Mandatory items are not completed the record will not pass validation tests R = Required: This data item where applicable should be submitted as soon as possible, but is not required to validate the submitted record.

	O = Optional: This item may be submitted at the discretion of the Provider. (It is either not currently required nationally or it will be obtained/derived by the National Cancer Registration Service from other sources). P = For use in a pilot project only at present to study the feasibility and potential benefits of using SNOMED CT. Please contact cosd@ncin.org.uk for further details. X = Not applicable for schema: This data item should not be included in the submission. (It will be obtained/derived by the National Cancer Registration Service from other sources).

Note: Data items shaded in grey in the User Guide and COSD Dataset do not need to be submitted directly by Providers for COSD.

0.3 National Codes

Where there is a defined list of values for a data item, the code appears on the left of the table and the definition appears on the right, as shown in the example below.

National Code	Definition
1	1 to 3
2	4 or more
U	Number uncertain

0.4 Patient Pathway

There should be one record for each primary cancer diagnosis or a diagnosis of secondary or metastatic cancer (recurrence)[1]. Providers are responsible for completing any sections of the patient pathway which were carried out by them and should agree with other organisations in the patient pathway as to who is responsible for submitting data items for different sections.

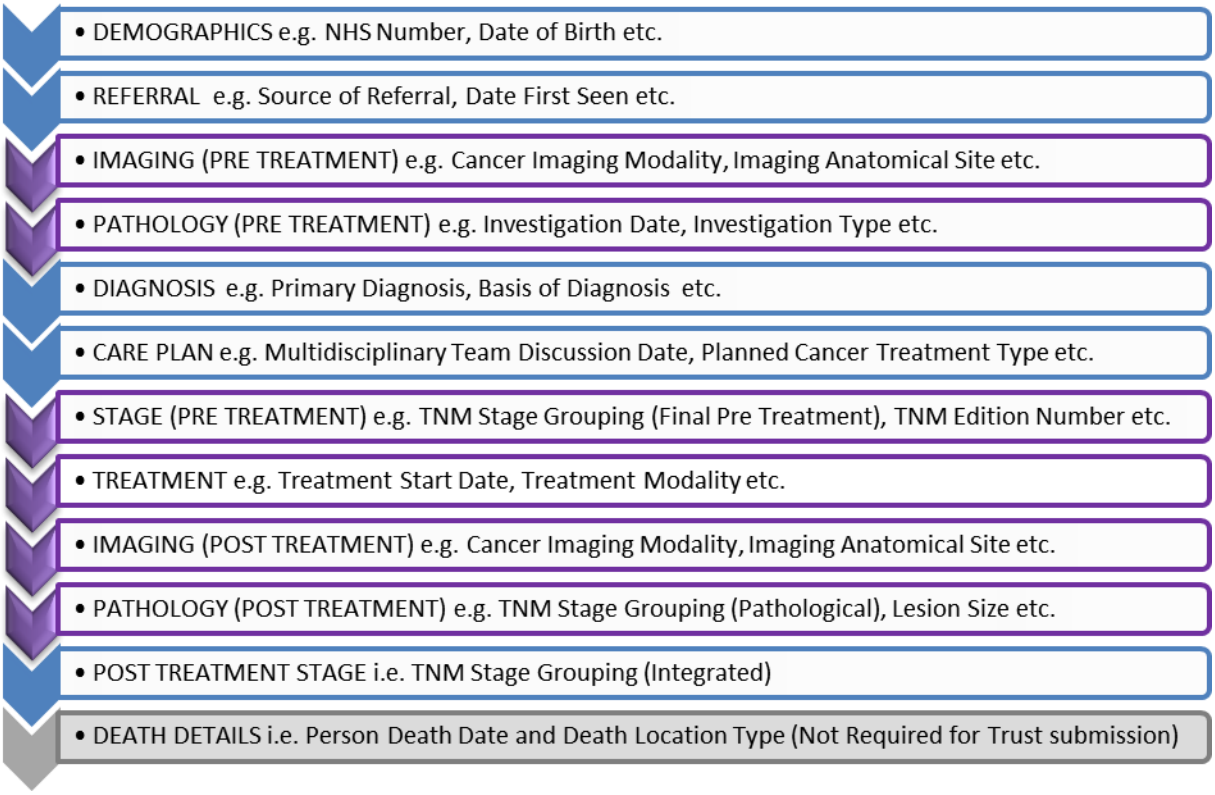
The diagnosis will normally trigger the registration record so details prior to diagnosis may be completed retrospectively.

The patient pathway may take several months and the record may not therefore be complete at the first submission. Providers should ensure that all details are submitted as soon as available and any updates to the records should be submitted monthly.

Cancer Patient's Pathway for a New Primary Diagnosis

The diagram below illustrates the main sections of the cancer patient's pathway which need to be completed for a new primary diagnosis. The sections highlighted in **purple** may be collected more than once.

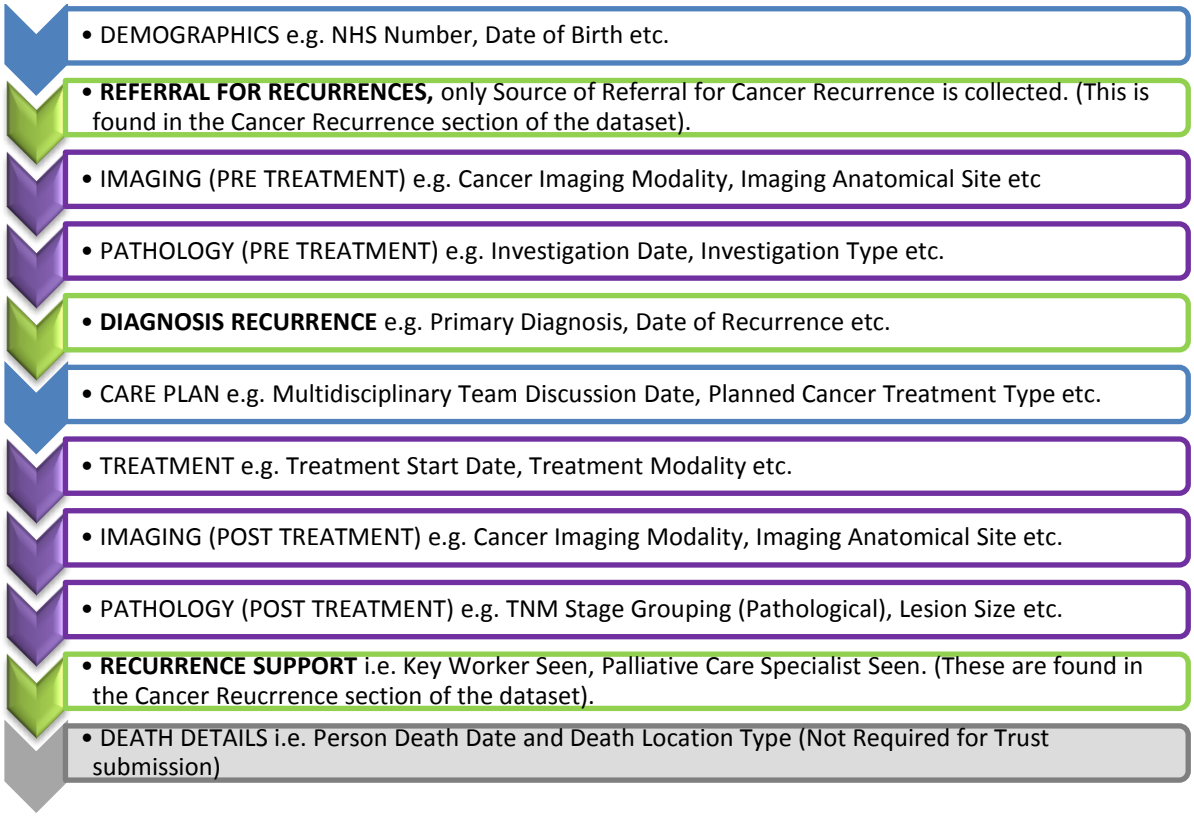
[1] Currently only Breast recurrences are required



Cancer Patient's Pathway for a Recurrence

A new record is required for each recurrence[2]. The diagram below illustrates the main sections of the cancer patient's pathway which need to be completed for a recurrence as detailed in COSD. The sections highlighted in **purple** may be collected more than once. The sections highlighted in **green** include different data items from the primary diagnosis record.

[2] Currently only Breast recurrences are required



0.5 Demographics

Demographic details are required for every record in order to ensure that the correct patient can be identified and information can be correctly linked.

The Demographics section should be completed by every Provider the first time a record is submitted.

There will only be one Demographics section completed for each record. Demographic linkage items will be required each time the record is submitted. Almost all patients should have an NHS Number and this should always be included where available. For those who do not have an NHS Number, the hospital number (LOCAL PATIENT IDENTIFIER) must be provided.

0.6 Referrals

This section includes details from referral up to the first appointment and is therefore to be recorded once for each cancer diagnosis. For some cases this is already recorded and submitted for Cancer Waiting Times. For the COSD this information is required for all cases. This is essential to support analysis for outcomes and work on presentation and routes to diagnosis. Further guidance on how various scenarios should be recorded is included in Appendix J.

There will only be one Referral section completed for each record.

0.7 Imaging

Imaging procedures carried out to diagnose or stage the cancer are included in this section. Most of the fields in this section are also extracted for the Diagnostic Imaging Dataset (DIDS).

Generic (core) imaging data may be provided through alternative methods and should be discussed with the local office of the NCRS.

Details of specific imaging procedures and outcomes required for specific disease groups are included in the appropriate site specific sections and must be included in monthly submissions.

There may be more than one Imaging section completed for each record.

Note: Imaging carried out post treatment should also be available

0.8 Diagnosis

Diagnosis details in the linkage section are required for every record in order to ensure that the correct record can be identified and information can be correctly linked. The full diagnosis details section enables the disease to be correctly registered. All registerable conditions should be recorded – see Appendix B.

Recording an applicable diagnosis including a Date of Diagnosis triggers inclusion of the record in the submission. Please refer to site specific sections for applicable ICD10 and/or ICDO3 codes. This information will normally be confirmed by the Multidisciplinary Team at their MDT Meeting.

Both ICD10 codes and Morphology (SNOMED and/or ICD03) must be completed for all cases.

ICD03 Topography Codes do not need to be completed by Providers.

There will only be one Diagnosis section completed for each record. Diagnosis linkage items will be required each time the record is submitted.

0.9 Cancer Care Plan

This section includes details applicable to care planning, including performance status, prognostic factors and treatment options which are normally discussed at the MDT meeting. Many of the site specific data items will be recorded at this point in the patient pathway. See site specific sections for further details.

There will only be one Cancer Care Plan section completed for each record. Most of the data items in this section will normally be available at the meeting at which the first definitive treatment was discussed.

Please note that some of the data items in the Care Plan sections of the site specific datasets will only be available after the initial treatment has been completed or at a subsequent MDT discussion. The items in this section will not therefore necessarily relate to the date of the MDT recorded (**MULTIDISCIPLINARY TEAM DISCUSSION DATE (CANCER)).**

0.10 Stage

This relates to the extent and spread of the tumour. For COSD the stage may be recorded at three points in the patient pathway:

- Pre-treatment: usually assessed at the MDT meeting where the treatment options are agreed
- Pathological stage: (recorded in the Pathology section)
- Integrated stage: following surgical treatment and/or final review of the case*

For most cancers TNM staging is used but see site specific sections for relevant TNM values and for other staging systems used. Where (p) is shown in the staging tables, this indicates that the code is also applicable for pathology.

The core staging section is not applicable to Haematology or Skin diagnoses; however relevant staging data items are included in the Haematology and Skin datasets.

There will only be one Staging section completed for each record. (Pathological stage may be recorded more than once).

General guidance on the expected staging system by tumour type is included in Appendix E.

Use of MX and M0

TNM editions prior to TNM7 included the category MX to identify when distant metastases could not be assessed. TNM7 removed this category, because the overuse of the MX category meant that a large proportion of tumours was not staged (a TNM group stage cannot be applied if MX is used).

According to the rules of TNM7, M0 should be used if there is no positive evidence of distant metastases. However, clinical practice in the UK has persisted in using the MX category.

The National Staging Panel for Cancer Registration wishes to propose a modification to TNM7 to be used in England and retain the use of MX in specific circumstances and to introduce M9. Please see Appendix N for further guidance.

Note: Where the pathological stage was recorded after the patient had received neoadjuvant therapy (i.e. chemotherapy or radiotherapy prior to surgery), the integrated stage may be the same as the pre-treatment stage.

Neuroendocrine Tumours

These are currently staged using the EUROPEAN NEUROENDOCRINE TUMOUR SOCIETY TNM Staging System. Where this staging system is used, the values should be recorded in the generic TNM stage fields in the core dataset. The TNM EDITION NUMBER should be recorded as "E".

0.11 Treatment

The initial record is completed up to the first treatment but all subsequent treatments are also required. Treatments are also reported for cases covered by Cancer Waiting Times although some additional details are included in COSD in both generic core and site specific sections.

There may be more than one Treatment section completed for each record.

0.12 Pathology

Pathological diagnosis and grade (where applicable) are recorded on biopsies and may be amended after surgical resection (if appropriate), when pathological staging should also be available. Full text pathology reports should be submitted to include these data items if structured coded extracts are not available.

There may be more than one Pathology section completed for each record.

0.13 Death

Details of death are obtained by the National Cancer Registration Service from ONS but may be submitted by Providers where available.

There may only be one Death section completed for each record.

0.14 Linkage Data Items

In order to ensure that records submitted can be linked appropriately some key data fields must be completed for each record submitted. These are shown at the start of the Core Dataset Section and further details are included in the relevant Demographics and Diagnosis sections.

There will be one linkage section completed each time the record is submitted.

0.15 Recording Recurrences

A new record needs to be completed for a diagnosed recurrence (metastatic or secondary), linked to the primary diagnosis by the PRIMARY DIAGNOSIS (ICD) in the CORE – DIAGNOSTIC DETAILS Section. Ultimately a complete record should be submitted for every diagnosis of recurrence, but at present only Breast recurrence records are required. All pathology reports which relate to recurrences, for any tumour site, should also continue to be submitted.

CORE DATA ITEMS REQUIRED FOR RECURRENCE RECORD

The following identifies the sections and items which are essential in order to register recurrences accurately.

(The REFERRALS, CLINICAL TRIALS and STAGING Sections are not currently required for Recurrences but all other sections are applicable.)

SECTION	*Specific Fields*	*Comments*
CORE – PATIENT IDENTITY DETAILS	ALL FIELDS including PRIMARY DIAGNOSIS (ICD)	Linkage to any other records or submissions for this patient. Note: The Primary Diagnosis field should always contain the original diagnosis code unless the primary is unknown.
CORE – DIAGNOSTIC DETAILS	ALL FIELDS - including DATE OF RECURRENCE (CLINICALLY AGREED)	Linkage to primary record, other submissions for this recurrence, and any other recurrences of this cancer. DATE OF RECURRENCE (CLINICALLY AGREED) is specific to recurrences and MUST be completed for all records submitted
CORE – DEMOGRAPHICS	ALL RELEVANT FIELDS	Patient details are essential for record matching and for data quality and assurance
CORE – IMAGING	ALL FIELDS	(Pre/post treatment. To assist with staging and identification of regional recurrence)
CORE – DIAGNOSIS	ALL FIELDS – including METASTATIC SITE and CANCER RECURRENCE CARE PLAN INDICATOR	All fields should be completed if possible. METASTATIC SITE and CANCER RECURRENCE CARE PLAN INDICATOR are used, with Imaging and Pathology, to identify local, regional and distant recurrences where no treatment is received
CORE – CANCER CARE PLAN	ALL APPLICABLE FIELDS – including MULTIDISCIPLINARY TEAM DISCUSSION INDICATOR and CLINICAL NURE SPECIALIST INDICATION CODE	To monitor service
CORE – TREATMENT	ALL APPLICABLE FIELDS	All treatment details should be completed, including non-active treatments such as specialist or non-specialist palliative support
CORE – SURGERY AND OTHER PROCEDURES, RADIOTHERAPY, ACTIVE MONITORING	ALL APPLICABLE FIELDS	These sections should be completed if applicable

CORE – PATHOLOGY	ALL APPLICABLE FIELDS	All Pathology details should be completed and should normally be submitted directly from the pathology system. Free text reports containing the pathological data items will currently be accepted as long as the linkage fields can be identified.
CORE – CANCER RECURRENCE	SOURCE OF REFERRAL FOR CANCER RECURRENCE KEY WORKER SEEN INDICATOR (CANCER RECURRENCE) PALLIATIVE CARE SPECIALIST SEEN INDICATOR (CANCER RECURRENCE)	These fields are specific to recurrences and MUST be completed for all records submitted.

ADDITIONAL SITE SPECIFIC DATA ITEMS REQUIRED FOR BREAST RECURRENCE RECORD

In addition to the CORE data items above, the following should also be completed from the site specific Breast dataset

SECTION	***Specific Fields***	***Comments***
BREAST - REFERRALS	ALL FIELDS	These fields relate to the assessment which led to the diagnosis of recurrence.
BREAST - IMAGING (MAMMOGRAM)	ALL FIELDS IF APPLICABLE	Contribute to diagnosis and stage assessment where no treatment recorded
BREAST - IMAGING (ULTRASOUND)	ALL FIELDS IF APPLICABLE	Contribute to diagnosis and stage assessment where no treatment recorded
BREAST - IMAGING (AXILLA ULTRASOUND)	ALL FIELDS IF APPLICABLE	Contribute to diagnosis and stage assessment where no treatment recorded
BREAST - PATHOLOGY	ALL FIELDS IF APPLICABLE	All Site Specific Pathology details should be completed and should normally be submitted directly from the pathology system. Free text reports containing the pathological data items will currently be accepted as long as the linkage fields can be identified.

1. CORE

ICD-10 CODES

The core data items should be collected for all cancers and other registerable conditions where applicable. See Appendix A to C for the full lists of ICD10 codes.

Note: For diagnoses not included in the site specific datasets, the core items only should be completed. For some registerable conditions only pathology reports will be available at present.

CORE LINKAGE

These items are required for every record in order to link patient records.

CORE – PATIENT IDENTITY DETAILS: NHS NUMBER and/or **LOCAL PATIENT IDENTIFIER, NHS NUMBER STATUS INDICATOR CODE, PERSON BIRTH DATE, ORGANISATION CODE (CODE OF PROVIDER).**

See Core-Demographics section for details.

CORE – DIAGNOSTIC DETAILS: PRIMARY DIAGNOSIS (ICD), DATE OF DIAGNOSIS (CLINICALLY AGREED) or **DATE OF RECURRENCE (CLINICALLY AGREED)**.

See Core-Diagnosis for details.

1.1 CORE – DEMOGRAPHIC DETAILS

To carry the patient demographic details. It is anticipated that some of the demographic data items listed below will be collected by every provider with which the patient has contact. Where this information is exchanged, the appropriate data item name should be used.

This section will be recorded once.

Patient identity details are required for linkage each time the record is submitted

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CR0010	CORE - PATIENT IDENTITY DETAILS	**NHS NUMBER**	n10	M[3]
CR0020	CORE - PATIENT IDENTITY DETAILS	**LOCAL PATIENT IDENTIFIER**	an10	M[4]
CR1350	CORE - PATIENT IDENTITY DETAILS	**NHS NUMBER STATUS INDICATOR CODE**	an2	M
CR0100	CORE - PATIENT IDENTITY DETAILS	**PERSON BIRTH DATE**	an10 ccyy-mm-dd	R
CR0030	CORE - PATIENT IDENTITY DETAILS	**ORGANISATION CODE (CODE OF PROVIDER)**	an3 or an5	M

[3] A combination of **NHS NUMBER** and/or **LOCAL PATIENT IDENTIFIER** is Mandatory for the schema

[4] A combination of **LOCAL PATIENT IDENTIFIER** and/or **NHS NUMBER** is Mandatory for the schema

CR0050	CORE - DEMOGRAPHICS	**PERSON FAMILY NAME**	max 35 characters	M
CR0060	CORE - DEMOGRAPHICS	**PERSON GIVEN NAME**	max 35 characters	M
CR0070	CORE - DEMOGRAPHICS	**PATIENT USUAL ADDRESS (AT DIAGNOSIS)**	an175 (5 lines each an35)	M
CR0080	CORE - DEMOGRAPHICS	**POSTCODE OF USUAL ADDRESS (AT DIAGNOSIS)**	max an8	M
CR0090	CORE - DEMOGRAPHICS	**PERSON GENDER CODE (CURRENT)**	an1	M
CR0110	CORE - DEMOGRAPHICS	**GENERAL MEDICAL PRACTITIONER (SPECIFIED)**	an8	R
CR0120	CORE - DEMOGRAPHICS	**GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)**	an6	M
CR0140	CORE - DEMOGRAPHICS	**PERSON FAMILY NAME (AT BIRTH)**	max 35 characters	R
CR0150	CORE - DEMOGRAPHICS	**ETHNIC CATEGORY**	an2	M

NHS NUMBER: The NHS NUMBER is a unique identifier for a PATIENT within the NHS in England and Wales. This will not vary by any ORGANISATION of which a PERSON is a PATIENT.

LOCAL PATIENT IDENTIFIER: For linkage purposes, NHS NUMBER and/or LOCAL PATIENT IDENTIFIER are required. This is a number used to identify a PATIENT uniquely within a Health Care Provider. It may be different from the PATIENT's casenote number and may be assigned automatically by the computer system.

NHS NUMBER STATUS INDICATOR CODE: The NHS NUMBER STATUS INDICATOR CODE indicates the verification status of the NHS number provided.

01	Number present and verified
02	Number present but not traced
03	Trace required
04	Trace attempted - No match or multiple match found
05	Trace needs to be resolved - (NHS Number or patient detail conflict)
06	Trace in progress
07	Number not present and trace not required
08	Trace postponed (baby under six weeks old)

PERSON BIRTH DATE: The date on which a PERSON was born or is officially deemed to have been born.

ORGANISATION CODE (CODE OF PROVIDER): The ORGANISATION CODE of the ORGANISATION acting as a Health Care Provider. This is the three digit code of the organisation submitting the demographic details. This will therefore normally be either the organisation where the referral is received or the treating organisation.

see ORGANISATION CODE

PERSON FAMILY NAME: That part of a PERSON's name which is used to describe family, clan, tribal group, or marital association.

PERSON GIVEN NAME: The forename(s) or given name(s) of a PERSON.

PATIENT USUAL ADDRESS (AT DIAGNOSIS): The PATIENT USUAL ADDRESS of the PATIENT at the time of PATIENT DIAGNOSIS.

POSTCODE OF USUAL ADDRESS (AT DIAGNOSIS): The POSTCODE OF USUAL ADDRESS of the PATIENT at the time of PATIENT DIAGNOSIS.

see POSTCODE

PERSON GENDER CODE (CURRENT): A PERSON's current gender.

0	Not Known
1	Male
2	Female
9	Not Specified

GENERAL MEDICAL PRACTITIONER (SPECIFIED): This is the code of the GENERAL MEDICAL PRACTITIONER specified by the PATIENT. This GENERAL MEDICAL PRACTITIONER works within the General Medical Practitioner Practice with which the PATIENT is registered.

GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION): This is the code of the GP Practice that the PATIENT is registered with.

PERSON FAMILY NAME (AT BIRTH): The PATIENT's surname at birth.

ETHNIC CATEGORY: The ethnicity of a PERSON, as specified by the PERSON. The 16+1 ethnic data categories defined in the 2001 census is the national mandatory standard for the collection and analysis of ethnicity.

(The Office for National Statistics has developed a further breakdown of the group from that given, which may be used locally.)

White	
A	(White) British
B	(White) Irish
C	Any other White background
Mixed	
D	White and Black Caribbean
E	White and Black African
F	White and Asian
G	Any other mixed background
Asian or Asian British	
H	Indian
J	Pakistani
K	Bangladeshi
L	Any other Asian background
Black or Black British	
M	Caribbean
N	African
P	Any other Black background
Chinese or Other Ethnic Group	
R	Chinese
S	Any other ethnic group
Z	Not stated
99	Not known

Note: The default option for this item is 99 "Not known"

1.2 CORE - REFERRALS AND FIRST STAGE OF PATIENT PATHWAY

To carry patient referral details for the Provider that receives the first referral. These details include information relating to the first stage of the Patient Pathway.

Note: This section will only be completed for Primary cancer diagnoses. For Recurrent cancers, the section labelled CANCER RECURRENCE/SECONDARY CANCER will be completed instead.
SOURCE OF REFERRAL FOR OUT-PATIENTS ***or*** **SOURCE OF REFERRAL FOR CANCER RECURRENCE** ***can be recorded.***

This section will be recorded once.

See Appendix J for Referral scenarios

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CR1600	CORE - REFERRALS	**SOURCE OF REFERRAL FOR OUT-PATIENTS**	an2	M
CR1580	CORE - REFERRALS	**REFERRAL TO TREATMENT PERIOD START DATE**	an10 ccyy-mm-dd	M
CR0230	CORE - REFERRALS	**DATE FIRST SEEN**	an10 ccyy-mm-dd	M
CR0210	CORE - REFERRALS	**CONSULTANT CODE (FIRST SEEN)**	an8	M
CR0220	CORE - REFERRALS	**CARE PROFESSIONAL MAIN SPECIALTY CODE (FIRST SEEN)**	an3	M
CR1410	CORE - REFERRALS	**ORGANISATION SITE CODE (PROVIDER FIRST SEEN)** *[SITE CODE (OF PROVIDER FIRST SEEN)]*	minimum length an5 maximum length an9	M
CR1360	CORE - REFERRALS	**DATE FIRST SEEN (CANCER SPECIALIST)**	an10 ccyy-mm-dd	M
CR1400	CORE - REFERRALS	**ORGANISATION SITE CODE (PROVIDER FIRST CANCER SPECIALIST)** *[SITE CODE (OF PROVIDER FIRST CANCER SPECIALIST)]*	minimum length an5 maximum length an9	M
CR0270	CORE - REFERRALS	**CANCER OR SYMPTOMATIC BREAST REFERRAL PATIENT STATUS**	an2	M
CR2000	CORE - REFERRALS	**CANCER SYMPTOMS FIRST NOTED DATE**	max an10 ccyy-mm-dd	R

SOURCE OF REFERRAL FOR OUT-PATIENTS (CWT): This identifies the source of referral of each Consultant Out-Patient Episode. This is essential for every cancer diagnosis in order to identify emergency presentations. Please note that where patients first present as an emergency, codes 01, 10 or 04 are applicable.
Note: Values in NBOCAP audit may differ.

Initiated by the CONSULTANT responsible for the Consultant Out-Patient Episode	
01	following an emergency admission
02	following a Domiciliary Consultation
10	following an Accident And Emergency Attendance (including Minor Injuries Units and Walk In Centres)
11	other - initiated by the CONSULTANT responsible for the Consultant Out-Patient Episode

Not initiated by the CONSULTANT responsible for the Consultant Out-Patient Episode	
03	referral from a GENERAL MEDICAL PRACTITIONER
92	referral from a GENERAL DENTAL PRACTITIONER
12	referral from a GENERAL PRACTITIONER with a Special Interest (GPwSI) or dentist with a Special Interest (DwSI)
04	referral from an Accident And Emergency Department (including Minor Injuries Units and Walk In Centres)
05	referral from a CONSULTANT, other than in an Accident And Emergency Department
06	self-referral
07	referral from a Prosthetist
13	referral from a Specialist NURSE (Secondary Care)
14	referral from an Allied Health Professional
15	referral from an OPTOMETRIST
16	referral from an Orthoptist
17	referral from a National Screening Programme
93	referral from a Community Dental Service
97	other - not initiated by the CONSULTANT responsible for the Consultant Out-Patient Episode

REFERRAL TO TREATMENT PERIOD START DATE (CWT)**:** The start date of a REFERRAL TO TREATMENT PERIOD. Date the initial referral which led to the cancer diagnoses was received by the Provider. If patient presented as an emergency it will be the date of the referral following that emergency presentation. . This may be different from CANCER REFERRAL TO TREATMENT PERIOD START DATE if initial referral was not to the cancer services teams.

DATE FIRST SEEN (CWT)**:** This is the date that the PATIENT is first seen in the Provider that receives the first referral which leads to the cancer diagnosis. It is the date first seen in secondary care for this diagnosis.

CONSULTANT CODE (FIRST SEEN): A code uniquely identifying a CONSULTANT. The CONSULTANT CODE is derived from either the GENERAL MEDICAL COUNCIL REFERENCE NUMBER for GENERAL MEDICAL PRACTITIONERS or the GENERAL DENTAL COUNCIL REGISTRATION NUMBER for GENERAL DENTAL PRACTITIONERS (where the dentist doesn't have a GENERAL MEDICAL COUNCIL REFERENCE NUMBER). This is the Code of the Consultant who is responsible for the appointment recorded under DATE FIRST SEEN.

CARE PROFESSIONAL MAIN SPECIALTY CODE (FIRST SEEN): A unique code identifying each MAIN SPECIALTY designated by Royal Colleges. This is the same as the OCCUPATION CODES describing specialties. (Can be derived from consultant code).

Codes 501 (Obstetrics) and 502 (Gynaecology) should be used and not the combined code 500 (Obstetrics and Gynaecology); this is in common with the requirements for central returns, including Hospital Episode Statistics.

See Main Specialty And Treatment Function Codes

ORGANISATION CODE (PROVIDER FIRST SEEN) (CWT)**:** The ORGANISATION SITE CODE of the Health Care Provider at the first contact with the PATIENT. That is the Health Care Provider at the first Out-Patient Attendance Consultant, Imaging or Radiodiagnostic Event, CLINICAL INTERVENTION, Hospital Provider Spell, Accident and Emergency Attendance or Screening Test whichever is the earlier SERVICE related to the initial REFERRAL REQUEST. It is the date first seen in secondary care for this diagnosis.

See ORGANISATION SITE CODE

DATE FIRST SEEN (CANCER SPECIALIST): This is the date that the PATIENT is first seen by the appropriate specialist for cancer care within a Cancer Care Spell. This is the PERSON or PERSONS who are most able to progress the diagnosis of the primary tumour. If patient's first appointment is with the appropriate cancer specialist this will be the same as DATE FIRST SEEN.

ORGANISATION CODE (PROVIDER FIRST CANCER SPECIALIST)*:* The ORGANISATION SITE CODE of the ORGANISATION acting as Health Care Provider where the PATIENT is first seen by an appropriate cancer specialist on the DATE FIRST SEEN (CANCER SPECIALIST). If patient's first appointment is with the appropriate cancer specialist this will be the same as ORGANISATION CODE (PROVIDER FIRST SEEN).

See ORGANISATION SITE CODE

CANCER OR SYMPTOMATIC BREAST REFERRAL PATIENT STATUS (CWT)**:** This is recorded to enable tracking of the status of REFERRAL REQUESTS for PATIENTS referred with a suspected cancer, or referred with breast symptoms with cancer not originally suspected. For COSD these definitions are extended to apply to all registerable conditions. However, those conditions not covered by Cancer Waits will need to be excluded from CWT uploads.

14	Suspected primary cancer
09	Under investigation following symptomatic referral, cancer not suspected (breast referrals only) (see note 1)
03	No new cancer diagnosis identified by the Healthcare Provider
10	Diagnosis of new cancer confirmed - first treatment not yet planned
11	Diagnosis of new cancer confirmed - English NHS first treatment planned
07	Diagnosis of cancer confirmed - no English NHS treatment planned
08	First treatment commenced (English NHS only)
12	Diagnosis of new cancer confirmed - subsequent treatment not yet planned
13	Diagnosis of new cancer confirmed - subsequent English NHS treatment planned
21	Subsequent treatment commenced (English NHS only)
15	Suspected recurrent cancer
16	Diagnosis of recurrent cancer confirmed - first treatment not yet planned
17	Diagnosis of recurrent cancer confirmed - English NHS first treatment planned
18	Diagnosis of recurrent cancer confirmed - no English NHS treatment planned
19	Diagnosis of recurrent cancer confirmed - subsequent treatment not yet planned
20	Diagnosis of recurrent cancer confirmed - subsequent English NHS treatment planned

CANCER SYMPTOMS FIRST NOTED DATE (MANDATORY FOR CTYA. OPTIONAL FOR ALL OTHERS):

Record the time when the symptoms were first noted related to this diagnosis as agreed between the consultant and the patient. This will normally be recorded by the consultant first seeing the patient in secondary care.

Depending on the length of time this should normally include at least the month and year. The day should also be included if known. If symptoms have been present for a long time then it may only be possible to record the year. In these various circumstances the Format/Length will be:

- *DATE (including year, month and day): CCYY-MM-DD*
- *YEAR AND MONTH: YYYY-MM*
- *YEAR ONLY: YYYY*

1.3 CORE – IMAGING

To carry imaging details.

This section can be recorded more than once.

Imaging carried out post treatment should also be submitted as part of the treatment record.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CR0310	CORE - IMAGING	**SITE CODE (OF IMAGING)**	Minimum length an5, maximum length an9	M
CR0320	CORE - IMAGING	**PROCEDURE DATE (CANCER IMAGING)**	an10 ccyy-mm-dd	M
CR1610	CORE - IMAGING	**IMAGING CODE (NICIP)**	max an6	M[5]
CR0330	CORE - IMAGING	**CANCER IMAGING MODALITY**	an4	M[6]
CR0340	CORE - IMAGING	**IMAGING ANATOMICAL SITE**	max an5	M[7]
CR3000	CORE - IMAGING	**ANATOMICAL SIDE (IMAGING)**	an1	M[8]
CR0160	CORE - IMAGING	**IMAGING REPORT TEXT**	max an270000	R
CR0350	CORE - IMAGING	**LESION SIZE (RADIOLOGICAL)**	max n3.max n2	R

Note: Image guided procedures (e.g. Image guided biopsies) should be recorded under surgery section.

SITE CODE (OF IMAGING): This is the ORGANISATION SITE CODE of the Organisation where the Imaging took place.

Note: This is not applicable for Skin diagnoses.

PROCEDURE DATE (CANCER IMAGING): The DATE the Cancer Imaging was carried out.

Note: This is not applicable for Skin diagnoses.

IMAGING CODE (NICIP): This is the National Interim Clinical Imaging Procedure Code Set code which is used to identify both the test modality and body site of the test. More information on NICIP can be found at the following link: http://www.isb.nhs.uk/library/standard/125.

Note: This is not applicable for Skin diagnoses.

[5] Either **IMAGING CODE (NICIP)** or a combination of **CANCER IMAGING MODALITY, IMAGING ANATOMICAL SITE** and **ANATOMICAL SIDE (IMAGING)** is Mandatory for the schema.

[6] Either **IMAGING CODE (NICIP)** or a combination of **CANCER IMAGING MODALITY, IMAGING ANATOMICAL SITE** and **ANATOMICAL SIDE (IMAGING)** is Mandatory for the schema.

[7] Either **IMAGING CODE (NICIP)** or a combination of **CANCER IMAGING MODALITY, IMAGING ANATOMICAL SITE** and **ANATOMICAL SIDE (IMAGING)** is Mandatory for the schema.

[8] Either **IMAGING CODE (NICIP)** or a combination of **CANCER IMAGING MODALITY, IMAGING ANATOMICAL SITE** and **ANATOMICAL SIDE (IMAGING)** is Mandatory for the schema.

As **IMAGING CODE (NICIP)** is used for the Diagnostic Imaging Dataset this should now be available to most systems and should be used in preference.

CANCER IMAGING MODALITY: (*Note: This is only required if NICIP is not available).* The type of imaging procedure used during an Imaging or Radiodiagnostic Event for a Cancer Care Spell.

Note: This is not applicable for Skin diagnoses.

C01X	Standard Radiography
C01M	Mammogram
C02X	CT Scan
C02C	Virtual colonoscopy
C03X	MRI Scan
C04X	PET Scan
C05X	Ultrasound Scan
C06X	Nuclear Medicine imaging
C08A	Angiography
C08B	Barium
C08U	Urography (IV and retrograde)
C09X	Intervention radiography.
CXXX	Other

IMAGING ANATOMICAL SITE: (*Note: This is only required if NICIP is not available).*

A classification of the part of the body that is the subject of an Imaging or Radiodiagnostic Event. The coding frame used is the OPCS-4 'Z' coding, plus two additional local codes:

- Whole body CZ001
- Multiple sites CZ002

For the purposes of recording Imaging Site for COSD the following high level codes are sufficient, although more detailed codes can be used if preferred:

Z921	Head NEC
Z923	Neck NEC
Z924	Chest NEC
Z925	Back NEC
Z926	Abdomen NEC
Z927	Trunk NEC
Z899	Arm NEC
Z909	Leg NEC
Z019	Brain NEC
Z069	Spine NEC
Z929	Other

Note: This is not applicable for Skin diagnoses.

ANATOMICAL SIDE (IMAGING): (*Note: This is only required if NICIP is not available).* The side of the body that is the subject of an Imaging or Radiodiagnostic Event.

Note: This is not applicable for Skin diagnoses.

L	Left
R	Right
M	Midline
B	Bilateral
8	Not applicable
9	Not Known

IMAGING REPORT TEXT *(optional):* This is the full text provided in the imaging report and may be required by registries to derive final stage and diagnosis date for registration.

Note: This is not applicable for Skin diagnoses.

LESION SIZE (RADIOLOGICAL): The size in millimetres of the maximum diameter of the primary lesion, largest if more than one.

Note: For COSD reporting purposes, this data item is not required to be submitted to two decimal places.

Note: This is not applicable for Skin diagnoses.

1.4 CORE – DIAGNOSIS

To carry the diagnosis details. This section will be agreed by the Multidisciplinary Team responsible for the patient and will probably be completed at the time the patient is discussed at the MDT meeting. The details may be different from those which appear in the Pathology data items.

This section will be recorded once.

Note: The three data items in the Diagnostic Details Section are required for linkage each time the record is submitted.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CR0370	CORE – DIAGNOSTIC	**PRIMARY DIAGNOSIS (ICD)**	an6	M
CR2030	CORE – DIAGNOSTIC	**DATE OF DIAGNOSIS (CLINICALLY AGREED)** *[DATE OF DIAGNOSIS (CANCER CLINICALLY AGREED)]*	an10 ccyy-mm-dd	M[9]
CR0440	CORE – DIAGNOSTIC	**DATE OF RECURRENCE (CLINICALLY AGREED)** *[DATE OF RECURRENCE (CANCER CLINICALLY AGREED)]*	an10 ccyy-mm-dd	M[10]
CR0380	CORE - DIAGNOSIS	**TUMOUR LATERALITY**	an1	M
CR0390	CORE - DIAGNOSIS	**BASIS OF DIAGNOSIS (CANCER)**	an1	M
CR0400	CORE - DIAGNOSIS	**MORPHOLOGY (SNOMED)**	max an18	M[11]
CR3030	CORE - DIAGNOSIS	**MORPHOLOGY (SNOMED CT)**	max n18	P
CR0180	CORE - DIAGNOSIS	**MORPHOLOGY (ICDO3)** *[MORPHOLOGY (ICD-O)]*	min an5 max an7	M[12]
CR0480	CORE - DIAGNOSIS	**TOPOGRAPHY (ICDO3)** *[TOPOGRAPHY (ICD-O)]*	min an5 max an7	R
CR0410	CORE - DIAGNOSIS	**GRADE OF DIFFERENTIATION (AT DIAGNOSIS)**	an2	R

[9] Either **DATE OF DIAGNOSIS ((CLINICALLY AGREED)** or **DATE OF RECURRENCE (CLINICALLY AGREED)** is Mandatory for the schema

[10] Either **DATE OF DIAGNOSIS ((CLINICALLY AGREED)** or **DATE OF RECURRENCE (CLINICALLY AGREED)** is Mandatory for the schema

[11] Either **MORPHOLOGY (SNOMED)** and/or **MORPHOLOGY (ICDO3)** is Mandatory for the schema

[12] Either **MORPHOLOGY (SNOMED)** and/or **MORPHOLOGY (ICDO3)** is Mandatory for the schema

CR1590	CORE - DIAGNOSIS	**METASTATIC SITE**	an2	R
CR0450	CORE - DIAGNOSIS	**CANCER RECURRENCE CARE PLAN INDICATOR**	an2	R

PRIMARY DIAGNOSIS (ICD): See DIAGNOSTIC CODING for details on coding and PRIMARY DIAGNOSES for the standardised definition of primary diagnosis.

The primary diagnosis is normally agreed at the MDT Meeting where the patient is discussed.

ICD10 is the International Statistical Classification of Diseases and Related Health Problems (ICD) and is a comprehensive classification of causes of morbidity and mortality. The primary diagnosis is the main condition treated or investigated during the relevant episode of healthcare.

Note: Where the ICD10 code only has 3 characters, eg C01, please add "X" as a 'packing digit' to meet the validation rules. (e.g. C01.X, C07.X, C73.X etc).

Format CXX.X or DXX.X

DATE OF DIAGNOSIS (CLINICALLY AGREED)*:* For linkage purposes this is required as mandatory. This is now the only Diagnosis date which Providers are required to submit for new primary cancers. Record the date where Cancer was confirmed or diagnosis agreed (This will normally be the date of the authorised pathology report which confirms the cancer or if this is not available at the time it will be the date of the Multidisciplinary Team Meeting when the diagnosis was agreed)

Note: This is not the same as DATE OF RECURRENCE (CANCER REGISTRATION) which is used for Cancer Registration. Providers are no longer required to record as Registries will derive this date from information received.

DATE OF RECURRENCE (CLINICALLY AGREED)*:* THIS DATA ITEM APPLIES TO RECURRENCES ONLY. This is now the only Diagnosis date which Providers are required to record for recurrences.

Record the date where Cancer recurrence was confirmed or diagnosis of recurrence was agreed (This will normally be the date of the authorised pathology report which confirms the recurrence or if this is not available at the time it will be the date of the Multidisciplinary Team Meeting when the diagnosis of recurrence was agreed)

Note: This is not the same as DATE OF RECURRENCE (CANCER REGISTRATION) which is used for Cancer Registration

TUMOUR LATERALITY (CWT)**:** Identifies the side of the body for a tumour relating to paired organs within a PATIENT. (This refers to the side of the body on which the cancer originates).

For the Central Nervous System, the definition for bilateral is 'evidence that the tumour is crossing the midline'.

L	Left
R	Right
M	Midline
B	Bilateral
8	Not applicable
9	Not known

BASIS OF DIAGNOSIS (CANCER): This is the method used to confirm the cancer.

Non-microscopic	
0	Death Certificate: The only information available is from a death certificate
1	Clinical: Diagnosis made before death but without the benefit of any of the following (2-7)
2	Clinical Investigation: Includes all diagnostic techniques (e.g. X-rays, endoscopy, imaging,

	ultrasound, exploratory surgery and autopsy) without a tissue diagnosis
4	Specific tumour markers: Includes biochemical and/or immunological markers which are specific for a tumour site
Microscopic	
5	Cytology: Examination of cells whether from a primary or secondary site, including fluids aspirated using endoscopes or needles. Also including microscopic examination of peripheral blood films and trephine bone marrow aspirates
6	Histology of a metastasis: Histological examination of tissues from a metastasis, including autopsy specimens
7	Histology of a primary tumour: Histological examination of tissue from the primary tumour, however obtained, including all cutting and bone marrow biopsies. Also includes autopsy specimens of a primary tumour
9	Unknown: No information on how the diagnosis has been made (e.g. PAS or HISS record only)

Either* MORPHOLOGY (SNOMED) *or* MORPHOLOGY (ICDO3) *should be submitted. For linkage purposes MORPHOLOGY (SNOMED) and/or MORPHOLOGY (ICDO3) is required.

MORPHOLOGY (ICD03) must be completed for all Haematology diagnoses. ***Note: Please see the Haematology Site Specific dataset for further details about collection this data item, including site specific values to be used.***

MORPHOLOGY (SNOMED): This is the PATIENT DIAGNOSIS for the cell type of the malignant disease recorded as part of a Cancer Care Spell. This can be recorded as well as or instead of **MORPHOLOGY (ICDO3).**

Format: MXXXXX

MORPHOLOGY (SNOMED CT): This is the PATIENT DIAGNOSIS using the SNOMED CT code for the cell type of the malignant disease recorded as of a Cancer Care Spell.

Note: For use in pilot project only at present. Please contact cosd@ncin.org.uk for further details.

MORPHOLOGY (ICDO3): The morphology code for the diagnosed cancer as defined by ICDO3.

Format: MXXXXX or MXXXXXX (see Haematology Section 7.2)

TOPOGRAPHY (ICDO3): (OPTIONAL). The topographical site code for the tumour as defined by ICDO3. This will normally be derived by Registries.

Format CXX.X

GRADE OF DIFFERENTIATION (AT DIAGNOSIS): is the definitive grade of the Tumour at the time of PATIENT DIAGNOSIS.

Note: Required for all Urological cancers except prostate and testis cancer. This data item is not applicable to CNS or Haematology diagnosis.

GX	Grade of differentiation is not appropriate or cannot be assessed
G1	Well differentiated
G2	Moderately differentiated
G3	Poorly differentiated
G4	Undifferentiated / anaplastic

METASTATIC SITE (CWT)**:** The site of the metastatic disease, if any, at diagnosis.

(Note that for Cancer Waits this item cannot be reported for first treatments unless that first treatment is a first treatment of a metastatic cancer following an unknown primary cancer, for COSD this should be recorded for all cases where applicable at diagnosis).

Note: This is not applicable for Haematological diagnosis.

02	Brain
03	Liver

04	Lung
06	Multiple metastatic sites
07	Unknown metastatic site
08	Skin
09	Distant lymph nodes
10	Bone (excluding bone marrow)
11	Bone marrow
99	Other metastatic site

CANCER RECURRENCE CARE PLAN INDICATOR: An indication of whether a diagnosis of recurrence has been recorded for which a new Cancer Care Plan is required. A new record should be completed for a recurrence.

YL	Yes, including local recurrence
YD	Yes, not including local recurrence
NN	No, not recurrence

1.5 CORE - CANCER CARE PLAN

To carry cancer care plan details where a treatment planning decision was made.

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CR0420	CORE - CANCER CARE PLAN	**MULTIDISCIPLINARY TEAM DISCUSSION INDICATOR**	an1	M
CR0430	CORE - CANCER CARE PLAN	**MULTIDISCIPLINARY TEAM DISCUSSION DATE (CANCER)**	an10 ccyy-mm-dd	R
CR0460	CORE - CANCER CARE PLAN	**CANCER CARE PLAN INTENT**	an1	R
Start of repeating item - Planned Cancer Treatment Type				
CR0470	CORE - CANCER CARE PLAN	**PLANNED CANCER TREATMENT TYPE**	an2	R
End of repeating item - Planned Cancer Treatment Type				
CR0490	CORE - CANCER CARE PLAN	**NO CANCER TREATMENT REASON**	an2	R
CR2060	CORE - CANCER_CARE_PLAN	**ADULT COMORBIDITY EVALUATION - 27 SCORE**	an1	R
CR0510	CORE - CANCER CARE PLAN	**PERFORMANCE STATUS (ADULT)**	an1	R
CR2050	CORE - CANCER_CARE_PLAN	**CLINICAL NURSE SPECIALIST INDICATION CODE**	an2	M

MULTIDISCIPLINARY TEAM DISCUSSION INDICATOR (CWT)**:** Please see Cancer Waiting Times dataset for definition.

MULTIDISCIPLINARY TEAM DISCUSSION DATE (CANCER) (CWT)**:** Please see Cancer Waiting Times dataset for definition.

CANCER CARE PLAN INTENT: The intention of a Cancer Care Plan developed within a Cancer Care Spell.

This only needs to be recorded when the first care plan is agreed.

C	Curative
Z	Non Curative

X	No active treatment
9	Not known

PLANNED CANCER TREATMENT TYPE: This is the clinically proposed treatment, usually agreed at a Multi-Disciplinary Team Meeting, and may not be the same as the treatment which is subsequently agreed with the patient. More than one planned treatment type may be recorded and these may either be alternative or sequential treatments.

This only needs to be recorded when the first treatment planning decision is made.

01	Surgery
02	Teletherapy
03	Chemotherapy
04	Hormone therapy
05	Specialist palliative care
06	Brachytherapy Therapy
07	Biological Therapy
10	Other Active Treatment
11	No active treatment
12	Biphosphonates
13	Anti Cancer Drug - Other
14	Radiotherapy - Other
99	Not known

Mapping against actual treatment. The following table shows how the treatment modality as defined in Cancer Waiting Times will map to these proposed treatment types.

Overall treatment type	CODE	PLANNED CANCER TREATMENT TYPE	CODE	CANCER TREATMENT MODALITY	*Treatment Group as reported for CWT*
SURGERY	1	Surgery	1	Surgery	*SURGERY*
RADIOTHERAPY	2	Teletherapy	5	Teletherapy (Beam Radiation excluding Proton Therapy)	*RADIOTHERAPY*
	6	Brachytherapy	6	Brachytherapy	*RADIOTHERAPY*
	14	Radiotherapy - Other	4	Chemoradiotherapy *(Do not record planned treatment under chemotherapy)*	*RADIOTHERAPY*
			13	Proton Therapy	*RADIOTHERAPY*
			19	Radioisotope Therapy (including Radioiodine)	*(Not recorded in Radiotherapy for CWT reporting)*
			22	Radiosurgery	*(Not recorded in Radiotherapy for CWT reporting)*
ANTI CANCER DRUGS	3	Chemotherapy	2	Anti-cancer drug regimen (Cytotoxic Chemotherapy)	*DRUG TREATMENTS*

	4	**Hormone therapy**	**3**	**Anti-cancer drug regimen (Hormone Therapy)**	*DRUG TREATMENTS*
	7	**Biological**	**21**	**Biological Therapies (excluding Immunotherapy)**	*(Not recorded in Anti Cancer Drug treatments for CWT reporting)*
			15	**Anti-cancer drug regimen (Immunotherapy)**	*DRUG TREATMENTS*
	13	**Anti Cancer Drug - Other**	**14**	**Anti-cancer drug regimen (other)**	*DRUG TREATMENTS*

OTHER ACTIVE TREATMENTS	**10**	**Other Active Treatment**	**12**	**Cryotherapy**	*OTHER*
			16	**Light Therapy (including Photodynamic Therapy and Psoralen and Ultra Violet A (PUVA) Therapy)**	*OTHER*
			20	**Laser Treatment (including Argon Beam therapy)**	
			97	**Other Treatment** *(active treatment)*	*("Other treatment" does not distinguish between active and non active for CWT reporting)*
			10	**Radio Frequency Ablation (RFA)**	*OTHER*
			11	**High Intensity Focussed Ultrasound (HIFU)**	*OTHER*

SPECIALIST PALLIATIVE TREATMENT	**5**	**Specialist palliative care**	**7**	**Specialist Palliative Care**	*PALLIATIVE TREATMENTS*

NON ACTIVE TREATMENT	**11**	**No active treatment** (*Only record planned treatments as "no active treatment" if only non active treatments are currently planned)*	**8**	**Active Monitoring (excluding non-specialist Palliative Care)**	*PALLIATIVE*
			9	**Non-specialist Palliative Care (excluding Active Monitoring)**	*PALLIATIVE*
			98	**All treatment declined**	*DECLINED*
			17	**Hyperbaric Oxygen Therapy (Only record here if there are no active treatments planned**	*OTHER*

			23	**Other Treatment** *(not active treatment.*	*("Other treatment" does not distinguish between active and non active for CWT reporting)*
	12	**BIPHOSPHONATES**	**23**	**Other Treatment** *(biphosponates)*	*OTHER*
NOT KNOWN	**99**	**Not known***			

OTHER ACTIVE TREATMENTS	**10**	**Other Active Treatment**	**12**	**Cryotherapy**	*OTHER*
			16	**Light Therapy (including Photodynamic Therapy and Psoralen and Ultra Violet A (PUVA) Therapy)**	*OTHER*
			20	**Laser Treatment (including Argon Beam therapy)**	
			23	**Other Treatment** *(active treatment)*	*("Other treatment" does not distinguish between active and non active for CWT reporting)*
			10	**Radio Frequency Ablation (RFA)**	*OTHER*
			11	**High Intensity Focussed Ultrasound (HIFU)**	*OTHER*

SPECIALIST PALLIATIVE TREATMENT	**5**	**Specialist palliative care**	**7**	**Specialist Palliative Care**	*PALLIATIVE TREATMENTS*

NON ACTIVE TREATMENT	**11**	**No active treatment (***Only record planned treatments as "no active treatment" if only non-active treatments are*	**8**	**Active Monitoring (excluding non-specialist Palliative Care)**	*PALLIATIVE*
			9	**Non-specialist Palliative Care (excluding Active Monitoring)**	*PALLIATIVE*
			98	**All treatment declined**	*DECLINED*

		currently planned)	**17**	**Hyperbaric Oxygen Therapy (Only record here if there are no active treatments planned**	*OTHER*
			23	**Other Treatment** *(not active treatment.*	*("Other treatment" does not distinguish between active and non active for CWT reporting)*
	12	**BIPHOSPHONATES**	**23**	**Other Treatment** *(biphosponates)*	*OTHER*
NOT KNOWN	**99**	**Not known***			

NO CANCER TREATMENT REASON: The main reason why no active cancer treatment is specified within a Cancer Care Plan.

01	Patient declined treatment
02	Unfit: poor performance status
03	Unfit: significant co-morbidity
04	Unfit: advanced stage cancer
05	Unknown primary site
06	Died before treatment
07	No active treatment available
08	Other
10	Monitoring only
99	Not known

ACE – 27 SCORE (ADULT COMORBIDITY EVALUATION – 27 SCORE): Overall Comorbidity Score is defined according to the highest ranked single ailment, except in the case where two or more Grade 2 ailments occur in different organ systems. In this situation, the overall comorbidity score should be designated Grade 3.

Note: ACE 27 scoring relates to co-morbidities and not the condition (Cancer) being treated.

Note: This is not applicable for Skin diagnoses.

Note: This is currently undergoing pilot testing to see if it feasible/appropriate to collect for all adult cancers. This is currently optional for local use.

0	None
1	Mild
2	Moderate
3	Severe

9	Not known

PERFORMANCE STATUS (ADULT): A World Health Organisation classification indicating a PERSON's status relating to activity / disability. This is the Performance Status agreed at the time that the treatment planning is carried out by the MDT.

This only need to be recorded once when the first treatment planning decision is made.

Note: This data item is not applicable for Paediatric patients or Skin diagnosis, except for melanoma stage 4.

0	Able to carry out all normal activity without restriction
1	Restricted in physically strenuous activity, but able to walk and do light work
2	Able to walk and capable of all self-care, but unable to carry out any work. Up and about more than 50% of waking hours
3	Capable of only limited self-care, confined to bed or chair more than 50% of waking hours
4	Completely disabled. Cannot carry on any self-care. Totally confined to bed or chair
9	Not recorded

Note: Code 5 (Dead) is not a valid classification under the WHO coding system

CLINICAL NURSE SPECIALIST INDICATION CODE: Record if and when the patient saw an appropriate site specific clinical nurse specialist. Note that this data item will enable several situations to be recorded e.g. whether the Clinical Nurse Specialist was present when the patient was given the diagnosis, whether the Clinical Nurse Specialist saw the patient at all and whether the Clinical Nurse Specialist was aware of the patient's diagnosis. Please therefore read all options in order to select the most appropriate code. (It is not as present possible to distinguish between Cancer Nurse Specialist and Clinical Nurse Specialist in the COSD.)

Although included in the section on Cancer Care Plan, this information will not necessarily be available at the meeting. It would be expected that this would be completed by the relevant nursing staff when appropriate. This will vary between specialties depending on patient pathway. As one of the intentions is to identify patients not seen by the Clinical Nurse Specialist it may not be possible to collect at time of patient contact.

Y1	Yes, including nurse present when patient given diagnosis
Y2	Yes, but nurse not present when patient given diagnosis
NI	No, patient not seen at all by nurse but nurse informed of diagnosis
NN	No, patient not seen at all by nurse and nurse not informed of diagnosis.
99	Not known

1.6 CORE - CLINICAL TRIALS

To carry clinical trial details for a patient who is eligible for a cancer clinical trial. Only one instance will be recorded for each diagnosis.

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CR1290	CORE - CLINICAL TRIALS	**PATIENT TRIAL STATUS (CANCER)**	an2	M
CR1260	CORE - CLINICAL TRIALS	**CANCER CLINICAL TRIAL TREATMENT TYPE**	an1	R

PATIENT TRIAL STATUS (CANCER): An indication of whether a PATIENT who is eligible for a cancer CLINICAL TRIAL is taking part in it.

EE	PATIENT eligible, consented to and entered trial
ED	PATIENT eligible, declined trial

CANCER CLINICAL TRIAL TREATMENT TYPE: The type of treatment covered by a cancer CLINICAL TRIAL. This is used to record the type(s) of treatment that are the subject of the cancer CLINICAL TRIAL into which the patient has been entered and does not necessarily mean the treatment that the patient will actually receive (which will be recorded only as part of the clinical trial documentation). Where a trial covers more than one type of treatment, eg chemotherapy compared with radiotherapy, then the option for "combined treatment" should be selected. Where the trial covers a treatment type not specified here, e.g. biological therapies, the data item should be left blank.

(This data item will be reviewed post implementation).

1	Surgery
2	Chemotherapy
3	Hormone therapy
4	Immunotherapy
5	Radiotherapy
6	Combination treatment
8	Other

1.7 CORE – STAGING

To carry the cancer staging details.

Both pre-treatment and integrated stage should be recorded in this section. UICC coding should be used.

Please refer to site specific sections for details of applicable values.

The pre-treatment stage fields are those on which the first treatment is based i.e. this final staging information available prior to first treatment.

Integrated stage fields should be recorded when all available information regarding stage has been assessed, following surgical treatment and/or final review of the case.*

Note: Arabic numerals should be used (i.e. submit in the format "1", "2a", "4" etc, NOT "Tia", "Tii"). Do not include TNM prefixes.

The National Staging Panel for Cancer Registration wishes to propose a modification to TNM7 to be used in England and retain the use of MX in specific circumstances. Please see Appendix N for further guidance.

This section will be recorded once.

This section is not applicable for Haematology or Skin. Please see site specific sections for other relevant staging.

Note: Where the pathological stage was recorded after the patient had received neoadjuvant therapy (i.e. chemotherapy or radiotherapy prior to surgery), the integrated stage may be the same as the pre-treatment stage.

Data Item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CR0520	CORE - STAGING	**T CATEGORY (FINAL PRETREATMENT)**	max an5	R
CR0540	CORE - STAGING	**N CATEGORY (FINAL PRETREATMENT)**	max an5	R

CR0560	CORE - STAGING	**M CATEGORY (FINAL PRETREATMENT)**	max an5	R
CR0580	CORE - STAGING	**TNM STAGE GROUPING (FINAL PRE TREATMENT)**	max an5	R
CR0620	CORE - STAGING	**T CATEGORY (INTEGRATED STAGE)**	max an5	R
CR0630	CORE - STAGING	**N CATEGORY (INTEGRATED STAGE)**	max an5	R
CR0640	CORE - STAGING	**M CATEGORY (INTEGRATED STAGE)**	max an5	R
CR0610	CORE - STAGING	**TNM STAGE GROUPING (INTEGRATED)**	max an5	R
CR2070	CORE - STAGING	**TNM EDITION NUMBER**	max an2	R

Note: The COSD Core Staging data items, mentioned below, are not applicable for CNS, Gynaecology, Haematology, Skin and most CTYA diagnosis. Please see site specific datasets for further information on collecting this data item, including the site specific values to be used.

T CATEGORY (FINAL PRETREATMENT): This is the UICC code which classifies the size and extent of the primary tumour before treatment.

N CATEGORY (FINAL PRETREATMENT): This is the UICC code which classifies the absence or presence and extent of regional lymph node metastases before treatment.

M CATEGORY (FINAL PRETREATMENT): This is the UICC code which classifies the absence or presence of distant metastases before treatment.

TNM STAGE GROUPING (FINAL PRE TREATMENT): Record the overall clinical TNM stage grouping of the tumour, derived from each T, N and M component prior to treatment. This classification is based on all the evidence available to the clinician(s) with responsibility for assessing the patient and for the patient's treatment plan. Such evidence arises from physical examination, imaging, endoscopy, biopsy, surgical exploration and other relevant examinations. The overall pre-treatment TNM stage grouping indicates the tumour stage at the time the treatment plan was devised.

T CATEGORY (INTEGRATED STAGE): This is the UICC code which classifies the size and extent of the primary tumour after treatment and/or after all available evidence has been collected.

N CATEGORY (INTEGRATED STAGE): This is the UICC code which classifies the absence or presence and extent of regional lymph node metastases after treatment and/or after all available evidence has been collected.

M CATEGORY (INTEGRATED STAGE): This is the UICC code which classifies the absence or presence of distant metastases after treatment and/or after all available evidence has been collected.

TNM STAGE GROUPING (INTEGRATED): Record the overall TNM stage grouping of the tumour, derived from each T, N and M component after treatment. This classification is based on all the evidence available to the clinician(s) with responsibility for assessing the patient. It will be determined on the basis of all the clinical, imaging and pathological data available following the first surgical procedure(s) i.e. this is the integration of the pathological staging with the clinical staging. The overall integrated TNM stage grouping indicates the tumour stage after treatment and/or after all available evidence has been collected.

Note: If the patient has had neoadjuvant therapy (i.e. Chemotherapy or Radiotherapy before surgical treatment) the integrated stage may be the same as the pre-treatment stage.

TNM EDITION NUMBER: The UICC edition number used for TNM staging for this cancer diagnosis. This is only recorded once for all the staging for each cancer diagnosis. It is expected that TNM EDITION will be consistent for all stage data for each diagnosis.

1.8 CORE – TREATMENT

To carry the cancer treatment details.

This section can be recorded more than once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CR1340	CORE - TREATMENT	**CANCER TREATMENT EVENT TYPE**	an2	M
CR1370	CORE - TREATMENT	**TREATMENT START DATE (CANCER)**	an10 ccyy-mm-dd	M
CR2040	CORE - TREATMENT	**CANCER TREATMENT MODALITY**	an2	M
CR1450	CORE - TREATMENT	**ORGANISATION SITE CODE (PROVIDER TREATMENT START DATE (CANCER)** *[SITE CODE (OF PROVIDER CANCER TREATMENT START DATE)]*	minimum length an5 maximum length an9	M
CR0660	CORE - TREATMENT	**CONSULTANT CODE (TREATMENT)**	an8	M
CR0670	CORE - TREATMENT	**CARE PROFESSIONAL MAIN SPECIALTY CODE (TREATMENT)**	an3	M

CANCER TREATMENT EVENT TYPE (CWT)**:** The stage of treatment reached during a Cancer PATIENT PATHWAY for primary, recurrent or metastatic cancer. For COSD these definitions are extended to apply to all registerable conditions. However, those conditions not covered by Cancer Waits will need to be excluded from CWT uploads.

01	First Definitive Treatment for a new primary cancer
02	Second or subsequent treatment for a new primary cancer
03	Treatment for a local recurrence of a primary cancer
04	Treatment for a regional recurrence of cancer
05	Treatment for a distant recurrence of cancer (metastatic disease)
06	Treatment for multiple recurrence of cancer (local and/or regional and/or distant)
07	First treatment for metastatic disease following an unknown primary
08	Second or subsequent treatment for metastatic disease following an unknown primary
09	Treatment for relapse of primary cancer (second or subsequent)
10	Treatment for progression of primary cancer (second or subsequent)

TREATMENT START DATE (CANCER) (CWT)**:** This is the Start Date of the first, second or subsequent cancer treatment given to a PATIENT who is receiving care for a cancer condition.

Applicable to all registered cases but see Cancer Waiting Times for definition.

CANCER TREATMENT MODALITY (CWT)**:** Applicable to all registered cases but see Cancer Waiting Times for definition and values. Applicable for active and non-active treatments, and to record where a patient declines treatment. Applies to all treatments at all stages in the patient pathway, including both primary cancer and recurrence.

ORGANISATION SITE CODE (PROVIDER TREATMENT START DATE (CANCER) (CWT)**:** Applicable to all registered cases but see Cancer Waiting Times for definition and values.

CONSULTANT CODE (TREATMENT): The Consultant code of the consultant responsible for the treatment of the patient.

CARE PROFESSIONAL MAIN SPECIALTY CODE (TREATMENT): The main specialty code of the consultant responsible for the treatment of the patient.

Codes 501 (Obstetrics) and 502 (Gynaecology) should be used and not the combined code 500 (Obstetrics and Gynaecology); this is in common with the requirements for central returns, including Hospital Episode Statistics.

See Main Specialty and Treatment Function Codes for the full list of valid codes.

1.9 CORE – TREATMENT: SURGERY AND OTHER PROCEDURES

To carry the surgery and other procedures details. This can be adapted for other procedures including interventional radiology, laser treatment, endoscopies etc. and photo-dynamic procedures. This also includes procedures offered as supportive care.

This section will be recorded once per treatment where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CR0680	CORE - SURGERY AND OTHER PROCEDURES	**CANCER TREATMENT INTENT**	an1	M
CR0710	CORE - SURGERY AND OTHER PROCEDURES	**PROCEDURE DATE**	an10 ccyy-mm-dd	M
CR0720	CORE - SURGERY AND OTHER PROCEDURES	**PRIMARY PROCEDURE (OPCS)**	an4	M
CR3040	CORE - SURGERY AND OTHER PROCEDURES	**PRIMARY PROCEDURE (SNOMED CT)**	max n18	P
Start of repeating item - Procedure (OPCS)				
CR0730	CORE - SURGERY AND OTHER PROCEDURES	**PROCEDURE (OPCS)**	an4	R
CR3050	CORE - SURGERY AND OTHER PROCEDURES	**PROCEDURE (SNOMED CT)**	max n18	P
End of repeating item - Procedure (OPCS)				
CR0740	CORE - SURGERY AND OTHER PROCEDURES	**DISCHARGE DATE (HOSPITAL PROVIDER SPELL)**	an10 ccyy-mm-dd	R
CR0750	CORE - SURGERY AND OTHER PROCEDURES	**DISCHARGE DESTINATION (HOSPITAL PROVIDER SPELL)**	an2	R

CANCER TREATMENT INTENT: The original intention of the cancer treatment provided during a Cancer Care Spell.

C	Curative
D	Diagnostic
S	Staging
P	Palliative
9	Not known

PROCEDURE DATE: The date the procedure was carried out.

PRIMARY PROCEDURE (OPCS): Primary procedure is the main procedure carried out.

PRIMARY PROCEDURE (SNOMED CT): Primary procedure is the main procedure carried out using SNOMED CT. This maybe recorded in addition to PRIMARY PROCEDURE (OPCS).

Note: For use in pilot project only at present. Please contact cosd@ncin.org.uk for further details.

PROCEDURE (OPCS): This is a procedure other than the PRIMARY PROCEDURE (OPCS), carried out and recorded for CDS or Hospital Episode Statistics purposes. (This may occur more than once).

PROCEDURE (SNOMED CT): This is a procedure other than the PRIMARY PROCEDURE, carried out and recorded for CDS or Hospital Episode Statistics purposes. (This may occur more than once).This maybe recorded in addition to PROCEDURE (OPCS).

Note: For use in pilot project only at present. Please contact cosd@ncin.org.uk for further details.

DISCHARGE DATE (HOSPITAL PROVIDER SPELL): The date a PATIENT was discharged from a Hospital Provider Spell.

DISCHARGE DESTINATION (HOSPITAL PROVIDER SPELL): This records the destination of a PATIENT on completion of the Hospital Provider Spell. It can also indicate that the PATIENT died.

19	Usual place of residence unless listed below, for example, a private dwelling whether owner occupied or owned by local authority, housing association or other landlord. This includes wardened accommodation but not residential accommodation where health care is provided. It also includes PATIENTS with no fixed abode.
29	Temporary place of residence when usually resident elsewhere (includes hotel, residential educational establishment)
30	Repatriation from high security psychiatric accommodation in an NHS Hospital Provider (NHS Provider)
37	Court
38	Penal establishment or police station
48	High Security Psychiatric Hospital, Scotland
49	NHS other hospital provider - high security psychiatric accommodation
50	NHS other hospital provider - medium secure unit
51	NHS other hospital provider - ward for general PATIENTS or the younger physically disabled
52	NHS other hospital provider - ward for maternity PATIENTS or neonates
53	NHS other hospital provider - ward for PATIENTS who are mentally ill or have learning disabilities
54	NHS run Care Home
65	Local Authority residential accommodation i.e. where care is provided
66	Local Authority foster care
79	Not applicable - PATIENT died or still birth
84	Non-NHS run hospital - medium secure unit
85	Non-NHS (other than Local Authority) run Care Home
87	Non-NHS run hospital
88	Non-NHS (other than Local Authority) run Hospice
Default Codes	
98	Not applicable - hospital provider spell not finished at episode end (i.e. not discharged, or current episode unfinished)
99	Not known

1.10 CORE – TREATMENT: RADIOTHERAPY

To carry the radiotherapy details. A course of radiotherapy is defined as a string of prescriptions which are consecutive. Only Brachytherapy is included here as all other Radiotherapy details are collected from other sources.

This section will be recorded once per treatment where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CR1200	CORE - RADIOTHERAPY	**BRACHYTHERAPY TYPE**	an2	R

BRACHYTHERAPY TYPE: The type of Brachytherapy Treatment Course being given.

BI	Interstitial
BC	Intra-cavity
BT	Not otherwise specified
US	Unsealed Source

Note: This data item is not applicable for Colorectal and Haematology diagnosis.

1.11 CORE – TREATMENT: ACTIVE MONITORING

To carry active monitoring details.

This section will be recorded once per treatment where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CR1240	CORE - ACTIVE MONITORING	**MONITORING INTENT**	an1	M

MONITORING INTENT: The purpose of monitoring a patient. This may only be used for first definitive treatment.

1	Monitoring with future curative intent
2	Monitoring with future palliative intent
3	Monitoring with unknown or uncertain future intent

Note: This data item is not applicable for Gynaecology diagnosis, although is particularly relevant to Urology, Lung and some Haematology diagnosis.

For Urology 'future curative intent' is equivalent to 'active monitoring/active surveillance'.

For Urology and Lung use 'future palliative intent' for 'watchful waiting'.

For Haematology this is applicable to most CLL, some Follicular Lymphomas and Myelodysplasias.

1.12 CORE – PATHOLOGY

To carry the pathology details. The core dataset includes general pathological items which are applicable to all tumour sites unless otherwise stated. Site specific pathology items relating to stage components are included in the site specific pathology sections. These core and site specific items are a subset of the RCPath cancer data sets which have been approved as Professional Standards by the College.

Where structured reporting systems are not available for pathology it is expected that many of the relevant data items will be included in the free text pathology report. Providers may also wish to submit these items from other structured systems such as MDT software, however the original pathology report should always be submitted and there is no expectation for Providers to double enter these data unless they have chosen to do so for local purposes.

A patient may have any number of pathology reports, and there may be more than one pathology report per specimen.

This section can be recorded more than once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CR0760	CORE - PATHOLOGY DETAILS	**PATHOLOGY INVESTIGATION TYPE**	an2	M
CR1010	CORE - PATHOLOGY DETAILS	**SAMPLE COLLECTION DATE**	an10 ccyy-mm-dd	R
CR0770	CORE - PATHOLOGY DETAILS	**SAMPLE RECEIPT DATE**	an10 ccyy-mm-dd	M
CR0780	CORE - PATHOLOGY DETAILS	**INVESTIGATION RESULT DATE**	an10 ccyy-mm-dd	M
CR0790	CORE - PATHOLOGY DETAILS	**CONSULTANT CODE (PATHOLOGIST)**	an8	M
CR0800	CORE - PATHOLOGY DETAILS	**ORGANISATION CODE (OF REPORTING PATHOLOGIST)**	an3 or an5	M
CR1020	CORE - PATHOLOGY DETAILS	**PATHOLOGY REPORT TEXT**	max an270000	R
CR0810	CORE - PATHOLOGY DETAILS	**PRIMARY DIAGNOSIS (ICD PATHOLOGICAL)**	an6	R
CR0820	CORE - PATHOLOGY DETAILS	**TUMOUR LATERALITY (PATHOLOGICAL)**	an1	M
CR0830	CORE - PATHOLOGY DETAILS	**LESION SIZE (PATHOLOGICAL)**	max n3.max n2	R
CR0840	CORE - PATHOLOGY DETAILS	**SYNCHRONOUS TUMOUR INDICATOR**	an1	R
CR0530	CORE - PATHOLOGY DETAILS	**TOPOGRAPHY (SNOMED)**	max an18	R
CR3070	CORE - PATHOLOGY DETAILS	**TOPOGRAPHY (SNOMED CT)**	max n18	P
CR0850	CORE - PATHOLOGY DETAILS	**MORPHOLOGY (SNOMED)**	max an18	M
CR3060	CORE - PATHOLOGY DETAILS	**MORPHOLOGY (SNOMED CT)**	max n18	P
CR0860	CORE - PATHOLOGY DETAILS	**GRADE OF DIFFERENTIATION (PATHOLOGICAL)**	an2	R
CR0870	CORE - PATHOLOGY DETAILS	**CANCER VASCULAR OR LYMPHATIC INVASION**	an2	R

CR0880	CORE - PATHOLOGY DETAILS	**EXCISION MARGIN**	an2	R
CR0890	CORE - PATHOLOGY DETAILS	**NUMBER OF NODES EXAMINED**	max n3	R
CR0900	CORE - PATHOLOGY DETAILS	**NUMBER OF NODES POSITIVE**	max n3	R
CR0910	CORE - PATHOLOGY DETAILS	**T CATEGORY (PATHOLOGICAL)**	max an5	R
CR0920	CORE - PATHOLOGY DETAILS	**N CATEGORY (PATHOLOGICAL)**	max an5	R
CR0930	CORE - PATHOLOGY DETAILS	**M CATEGORY (PATHOLOGICAL)**	max an5	R
CR0940	CORE - PATHOLOGY DETAILS	**TNM STAGE GROUPING (PATHOLOGICAL)**	max an5	R
CR1000	CORE - PATHOLOGY DETAILS	**NEOADJUVANT THERAPY INDICATOR**	an1	R
CR0950	CORE - PATHOLOGY DETAILS	**SERVICE REPORT IDENTIFIER**	max an18	M
CR0960	CORE - PATHOLOGY DETAILS	**SERVICE REPORT STATUS**	an1	M
CR0970	CORE - PATHOLOGY DETAILS	**SPECIMEN NATURE**	an1	M
CR0980	CORE - PATHOLOGY DETAILS	**ORGANISATION SITE CODE (PATHOLOGY TEST REQUESTED BY)** *[SITE CODE (OF PATHOLOGY TEST REQUEST)]*	minimum length an5 maximum length an9	R
CR0990	CORE - PATHOLOGY DETAILS	**CARE PROFESSIONAL CODE (PATHOLOGY TEST REQUESTED BY)**	an8	R

PATHOLOGY INVESTIGATION TYPE: The type of pathology investigation procedure carried out.

Note: Please see Skin site specific dataset for further information on collecting this data item, including the site specific values to be used.

CY	Cytology
BU	Biopsy NOS
EX	Excision
PE	Partial Excision
RE	Radical Excision
FE	Further Excision
CU	Curettage
SB	Shave Biopsy
PB	Punch Biopsy
IB	Incisional Biopsy

99	Uncertain/other

SAMPLE COLLECTION DATE: The date that a SAMPLE collection takes place or the start of a period for SAMPLE collection. This is the same as the date the Sample is taken.

SAMPLE RECEIPT DATE: Date of receipt of a SAMPLE by a LABORATORY.

INVESTIGATION RESULT DATE: The date on which an investigation was concluded e.g. the date the result was authorised.

CONSULTANT CODE (PATHOLOGIST): The CONSULTANT CODE of the Pathologist who authorises the pathology report.

ORGANISATION CODE (OF REPORTING PATHOLOGIST): This is the ORGANISATION CODE of the ORGANISATION at which the authorising pathologist is based.

See ORGANISATION CODE

PATHOLOGY REPORT TEXT: The full text from the pathology report which may be required by Registries to calculate diagnosis and staging details

PRIMARY DIAGNOSIS (ICD PATHOLOGICAL): The PRIMARY DIAGNOSIS based on the evidence from a pathological examination.

Format CXX.X or DXX.X

TUMOUR LATERALITY (PATHOLOGICAL): Tumour laterality identifies the side of the body for a tumour relating to paired organs within a PATIENT based on the evidence from a pathological examination.

L	Left
R	Right
M	Midline
B	Bilateral
8	Not applicable
9	Not known

LESION SIZE (PATHOLOGICAL): The size in millimetres of the diameter of a lesion, largest if more than one, if the histology of a SAMPLE proves to be invasive.

Note: For COSD reporting purposes, this data item is not required to be submitted to two decimal places.

Note: This data item is not applicable for Haematology diagnosis.

Note: Please see Skin site specific dataset for further information on collecting this data item, including the site specific values to be used.

SYNCHRONOUS TUMOUR INDICATOR: An indicator of the presence of multiple tumours at a tumour site.

N	No, no synchronous tumours present
Y	Yes, synchronous tumours present
9	Not Known

Note: This data item is not applicable for Haematology diagnosis.

TOPOGRAPHY (SNOMED): This is the topographical site of the tumour as categorised by SNOMED RT.

TOPOGRAPHY (SNOMED CT): This is the topographical site of the tumour as categorised by SNOMED CT.

Note: For use in pilot project only at present. Please contact cosd@ncin.org.uk for further details.

MORPHOLOGY (SNOMED): This is the morphology of the tumour as categorised by SNOMED RT.

Format: MXXXXX

MORPHOLOGY (SNOMED CT): This is the morphology of the tumour as categorised by SNOMED CT.

Note: For use in pilot project only at present. Please contact cosd@ncin.org.uk for further details.

GRADE OF DIFFERENTIATION (PATHOLOGICAL): The definitive grade of the Tumour based on the evidence from a pathological examination.

GX	Grade of differentiation is not appropriate or cannot be assessed
G1	Well differentiated
G2	Moderately differentiated
G3	Poorly differentiated
G4	Undifferentiated / anaplastic

Note: This data item is not applicable for CNS or Haematology diagnosis.

Note: Please see Skin site specific dataset for further information on collecting this data item, including the site specific values to be used, although this data item is not used for Melanoma, but is for Squamous Cell Carcinoma.

CANCER VASCULAR OR LYMPHATIC INVASION: An indication of the presence or absence of unequivocal tumour in lymphatic and/or vascular spaces.

NU	No - vascular/lymphatic invasion not present
YU	Yes - vascular/lymphatic invasion present
UU	Uncertain whether vascular/lymphatic invasion is present or not
YV	Vascular invasion only present
YL	Lymphatic invasion only present
YB	Both lymphatic and vascular invasion present
99	Not known

Note: This data item is not applicable for Haematology diagnosis.

EXCISION MARGIN: An indication of whether the excision margin was clear of the tumour and if so, by how much. Where there is more than one measurement, record the closest or closest relevant margin. Where actual measurements are not taken use options 01, 05 or 06.

01	Excision margins are clear (distance from margin not stated)
02	Excision margins are clear (tumour >5mm from the margin)
03	Excision margins are clear (tumour >1mm but less than or equal to 5mm from the margin
04	Tumour is less than or equal to 1mm of excision margin, but does not reach margin
05	Tumour reaches tumour margin
06	Uncertain
98	Not applicable
99	Not known

Note: This data item is not applicable for Haematology diagnosis.

NUMBER OF NODES EXAMINED: The number of local and regional nodes examined.

Note: This data item is not applicable for CNS, Haematology or Lung diagnosis.

NUMBER OF NODES POSITIVE: The number of local and regional nodes reported as being positive for the presence of Tumour metastases.

Note: This data item is not applicable for CNS, Haematology or Lung diagnosis.

Note: The COSD Core Staging data items mentioned below are not applicable for CNS, Gynaecology, Haematology, Skin and most CTYA diagnosis. Please see site specific datasets for further information on collecting these data item, including the site specific values to be used.

T CATEGORY (PATHOLOGICAL): T CATEGORY (PATHOLOGICAL) is the Union for International Cancer Control (UICC) code which classifies the size and extent of the primary Tumour based on the evidence from a pathological examination.

N CATEGORY (PATHOLOGICAL): N CATEGORY (PATHOLOGICAL) is the Union for International Cancer Control (UICC) code which classifies the absence or presence and extent of regional lymph node metastases based on the evidence from a pathological examination.

M CATEGORY (PATHOLOGICAL): The Union for International Cancer Control (UICC) code which classifies the absence or presence of distant metastases based on the evidence from a pathological examination.

TNM STAGE GROUPING (PATHOLOGICAL): The Union for International Cancer Control (UICC) code which classifies the combination of Tumour, node and metastases into stage groupings based on the evidence from a pathological examination.

NEOADJUVANT THERAPY INDICATOR: Indicator of whether the pathological stage was recorded after the patient had received neoadjuvant therapy (i.e. chemotherapy or radiotherapy prior to surgery).

Note: If this is "Yes" the pathology stage fields should be prefixed with the letter "y".

Y	Yes
N	No
9	Not known

SERVICE REPORT IDENTIFIER: A unique identifier of a SERVICE REPORT.

SERVICE REPORT STATUS: The status of the SERVICE REPORT.

1	Final (complete)
2	Preliminary (Interim)
3	Test not available
4	Unspecified
5	Supplementary/second opinion

SPECIMEN NATURE: The nature of the specimen taken during a Clinical Investigation.

1	Primary tumour
2	Further excision of primary tumour
4	Regional Lymph Nodes
5	Metastatic site other than regional lymph nodes
9	Not known

Where none of the above options are applicable, 'Not known' maybe selected.

ORGANISATION SITE CODE (PATHOLOGY TEST REQUESTED BY) The ORGANISATION SITE CODE of the ORGANISATION at which the CARE PROFESSIONAL who requested the DIAGNOSTIC TEST REQUEST for suspected cancer is based.

See ORGANISATION SITE CODE

CARE PROFESSIONAL CODE (PATHOLOGY TEST REQUESTED BY): The code of the CARE PROFESSIONAL who requests the pathology test. This is not required if the request comes from a GENERAL MEDICAL PRACTITIONER.

1.13 CORE - DEATH DETAILS

To carry death details (not required for direct submission by Providers).

This section is recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CR1270	CORE - DEATH DETAILS	**PERSON DEATH DATE**	an10 ccyy-mm-dd	M
CR1280	CORE - DEATH DETAILS	**DEATH LOCATION TYPE**	an1	R

PERSON DEATH DATE: The date on which a PERSON died or is officially deemed to have died.

DEATH LOCATION TYPE: The type of LOCATION at which a PERSON died.

1	Hospital
2	NHS hospice / specialist palliative care unit
3	Voluntary hospice / specialist palliative care unit
4	Patient's own home
5	Care Home
6	Other

1.14 CORE - CANCER RECURRENCE / SECONDARY CANCER

THE FOLLOWING SECTION IS ONLY APPLICABLE WHERE A DIAGNOSIS OF RECURRENT/SECONDARY/METASTATIC CANCER HAS BEEN MADE. THESE DETAILS ARE NOT APPLICABLE WHERE METASTATIC CANCER IS IDENTIFIED AT THE SAME TIME AS THE PRIMARY DIAGNOSIS. A NEW RECORD IS REQUIRED FOR EACH RECURRENCE DIAGNOSIS

To carry details of metastatic/secondary cancer (recurrence).

This section will be recorded once where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CR0440	CORE – DIAGNOSTIC DETAILS	**DATE OF RECURRENCE (CLINICALLY AGREED)**	an10 ccyy-mm-dd	M
CR0300	CORE - CANCER RECURRENCE / SECONDARY CANCER	**SOURCE OF REFERRAL FOR CANCER RECURRENCE**	an2	R
CR1540	CORE - CANCER RECURRENCE / SECONDARY CANCER	**KEY WORKER SEEN INDICATOR (CANCER RECURRENCE)**	an1	M
CR1550	CORE - CANCER RECURRENCE / SECONDARY CANCER	**PALLIATIVE CARE SPECIALIST SEEN INDICATOR (CANCER RECURRENCE)**	an1	M

SOURCE OF REFERRAL FOR CANCER RECURRENCE: (Recurrences only). This identifies the source of referral for a recurrence of cancer.

Note: Either* SOURCE OF REFERRAL FOR OUT-PATIENTS *or* SOURCE OF REFERRAL FOR CANCER RECURRENCE *can be recorded.

Initiated by the CONSULTANT responsible for the Consultant Out-Patient Episode	
01	Following an emergency admission
02	Following a Domiciliary Consultation
10	Following an Accident And Emergency Attendance (including Minor Injuries Units and Walk In Centres)
11	Other - initiated by the CONSULTANT responsible for the Consultant Out-Patient Episode
Not initiated by the CONSULTANT responsible for the Consultant Out-Patient Episode	
03	Referral from a GENERAL MEDICAL PRACTITIONER
92	Referral from a GENERAL DENTAL PRACTITIONER
12	R03eferral from a GENERAL PRACTITIONER with a Special Interest (GPwSI) or dentist with a Special Interest (DwSI)
04	Referral from an Accident And Emergency Department (including Minor Injuries Units and Walk In Centres)
05	Referral from a CONSULTANT, other than in an Accident And Emergency Department
06	Self-referral
07	Referral from a Prosthetist
13	Referral from a Specialist NURSE (Secondary Care)
14	Referral from an Allied Health Professional
15	Referral from an OPTOMETRIST
16	Referral from an Orthoptist
17	Referral from a National Screening Programme
93	Referral from a Community Dental Service
97	Other - not initiated by the CONSULTANT responsible for the Consultant Out-Patient Episode

KEY WORKER SEEN INDICATOR (CANCER RECURRENCE): Record whether the patient was seen by a designated key worker who was neither the clinical nurse specialist nor a palliative care specialist. This applies specifically to a recurrence of cancer.

Y	Yes
N	No
9	Not known (not recorded)

PALLIATIVE CARE SPECIALIST SEEN INDICATOR (CANCER RECURRENCE): Record whether the patient was seen by a palliative care specialist. This would be a member of the specialist palliative care team led by a consultant in palliative medicine. This applies to specifically to a recurrence of cancer.

Y	Yes
N	No
9	Not known (not recorded)

2. BREAST

OVERVIEW

TNM Staging and NPI Score should both be collected for invasive breast cancers. TNM stage is required to enable international comparisons. As for Cancer Waits the breast cancer site-specific dataset also includes in situ (non-invasive) breast cancers (D05) which are TNM Stage 0. NPI score is not used for non-invasive breast cancers.

Please also note that a separate record should be completed for each diagnosis of secondary/metastatic breast cancer (see Recording Recurrences, section 0. Using This Guide).

ICD-10 CODES

Key:

() = if applicable

* = different dataset from CWT group specified

ICD-10 All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C50.0	Nipple and areola	Breast	●			
C50.1	Central portion of breast	Breast	●			
C50.2	Upper-inner quadrant of breast	Breast	●			
C50.3	Lower-inner quadrant of breast	Breast	●			
C50.4	Upper-outer quadrant of breast	Breast	●			
C50.5	Lower-outer quadrant of breast	Breast	●			
C50.6	Axillary tail of breast	Breast	●			
C50.8	Overlapping lesion of breast	Breast	●			
C50.9	Breast, unspecified	Breast	●			
D05.0	Lobular carcinoma in situ	Breast	●			
D05.1	Intraductal carcinoma in situ	Breast	●			
D05.7	Other carcinoma in situ of breast	Breast	●			
D05.9	Carcinoma in situ of breast, unspecified	Breast	●			

D48.6	Neoplasm of uncertain or unknown behaviour of Breast	Breast			●	

2.1 BREAST – REFERRALS

To carry referral details for breast cancer.

This section can be recorded more than once within a referral.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
BR4000	BREAST - REFERRALS	**DATE OF CLINICAL ASSESSMENT**	an10 ccyy-mm-dd	M
BR4010	BREAST - REFERRALS	**ORGANISATION SITE CODE (OF CLINICAL ASSESSMENT)** *[SITE CODE (OF CLINICAL ASSESSMENT)]*	Minimum length an5, maximum length an9	M
BR4020	BREAST - REFERRALS	**CLINICAL ASSESSMENT RESULT (BREAST)** *[CLINICAL ASSESSMENT RESULT CODE (BREAST CANCER)]*	an2	M

DATE OF CLINICAL ASSESSMENT: Date of clinical/physical examination. This will normally be the date of the first outpatient appointment at the breast clinic. If the patient attends more than one breast clinic, the date of each clinical examination undertaken should be recorded.

ORGANISATION SITE CODE (OF CLINICAL ASSESSMENT)*:* Provider code where clinical/physical examination was carried out. This will normally be the site code of the first outpatient appointment at the breast clinic. If the patient attends more than one breast clinic, the site code of each breast clinic where a clinical/physical examination was undertaken should be recorded.

see ORGANISATION SITE CODE

CLINICAL ASSESSMENT RESULT (BREAST)*:* Result of the clinical/physical examination of the breast for which a cancer is registered. This will normally be the result of an assessment of a patient's clinical history and physical examination undertaken at the first outpatient appointment at the breast clinic. If the patient attends more than one breast clinic, the result of each clinical/physical examination undertaken should be recorded.

P1	Normal
P2	Benign
P3	Uncertain
P4	Suspicious
P5	Malignant

2.2 BREAST – IMAGING

To carry imaging mammogram, ultrasound and axilla ultrasound details for breast cancer.

These sections can be recorded more than once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
BREAST - IMAGING (MAMMOGRAM)				
Multiple occurrences of this data group are permitted				
BR4030	BREAST - IMAGING (MAMMOGRAM)	**PROCEDURE DATE (MAMMOGRAM)**	an10 ccyy-mm-dd	M
BR4040	BREAST - IMAGING (MAMMOGRAM)	**ORGANISATION SITE CODE (MAMMOGRAM)** *[SITE CODE (OF MAMMOGRAM)]*	Minimum length an5, maximum length an9	M
BR4050	BREAST - IMAGING (MAMMOGRAM)	**MAMMOGRAM RESULT** *[MAMMOGRAM RESULT CODE]*	an2	M
BREAST - IMAGING (ULTRASOUND)				
Multiple occurrences of this data group are permitted				
BR4060	BREAST - IMAGING (ULTRASOUND)	**PROCEDURE DATE (BREAST ULTRASOUND)**	an10 ccyy-mm-dd	M
BR4070	BREAST - IMAGING (ULTRASOUND)	**ORGANISATION SITE CODE (BREAST ULTRASOUND)** *[SITE CODE (OF BREAST ULTRASOUND)]*	Minimum length an5, maximum length an9	M
BR4080	BREAST - IMAGING (ULTRASOUND)	**BREAST ULTRASOUND EXAMINATION RESULT** *[BREAST ULTRASOUND RESULT CODE]*	an2	M
BREAST - IMAGING (AXILLA ULTRASOUND)				
Multiple occurrences of this data group are permitted				
BR4090	BREAST - IMAGING (AXILLA ULTRASOUND)	**PROCEDURE DATE (AXILLA ULTRASOUND)**	an10 ccyy-mm-dd	M
BR4100	BREAST - IMAGING (AXILLA ULTRASOUND)	**ORGANISATION SITE CODE (OF AXILLA ULTRASOUND)** *[SITE CODE (OF AXILLA ULTRASOUND)]*	Minimum length an5, maximum length an9	M
BR4110	BREAST - IMAGING (AXILLA ULTRASOUND)	**AXILLA ULTRASOUND EXAMINATION RESULT** *[AXILLA ULTRASOUND RESULT CODE]*	an2	M

PROCEDURE DATE (MAMMOGRAM): Date when mammography was carried out. This will normally be the date of the first outpatient appointment at the breast clinic. If the patient attends more than one breast clinic, the date that each mammogram was undertaken should be recorded.

ORGANISATION SITE CODE (MAMMOGRAM)*:* Provider code where mammography was carried out. This will normally be the site code of the first outpatient appointment at the breast clinic. If the patient attends more than one breast clinic, the site code of each breast clinic appointment where a mammogram was taken should be recorded.

see ORGANISATION SITE CODE

MAMMOGRAM RESULT: Result of the mammogram. This will normally be the result of the mammogram taken at the first outpatient appointment at the breast clinic. If the patient attends more than one breast clinic, the result of each mammogram should be recorded.

R1	Normal
R2	Benign

R3	Uncertain
R4	Suspicious
R5	Malignant

PROCEDURE DATE (BREAST ULTRASOUND): Date when the ultrasound examination of the breast was carried out. This will normally be the date of the first outpatient appointment at the breast clinic. If the patient attends more than one breast clinic, the date that each ultrasound examination of the breast was undertaken should be recorded.

ORGANISATION SITE CODE (BREAST ULTRASOUND): Provider code where ultrasound examination of the breast was carried out. This will normally be the site code of the first outpatient appointment at the breast clinic. If the patient attends more than one breast clinic, the site code of each breast clinic where ultrasound examination of the breast was undertaken should be recorded.

see ORGANISATION SITE CODE

BREAST ULTRASOUND EXAMINATION RESULT: Result of the ultrasound examination of the breast. This will normally be the result of the ultrasound examination of the breast undertaken at the first outpatient appointment at the breast clinic. If the patient attends more than one breast clinic, the result of each ultrasound examination of the breast should be recorded.

U1	Normal
U2	Benign
U3	Indeterminate/probably benign
U4	Suspicious of malignancy
U5	Highly suspicious of malignancy

PROCEDURE DATE (AXILLA ULTRASOUND): Date when the ultrasound examination of the axilla was carried out. This will normally be the date of the first outpatient appointment at the breast clinic. If the patient attends more than one breast clinic, the date that each ultrasound examination of the axilla was undertaken should be recorded.

ORGANISATION SITE CODE (OF AXILLA ULTRASOUND): Provider code where ultrasound examination of the axilla was carried out. This will normally be the site code of the first outpatient appointment at the breast clinic. If the patient attends more than one breast clinic, the site code of each breast clinic appointment where ultrasound examination of the axilla was carried out should be recorded.

see ORGANISATION SITE CODE

AXILLA ULTRASOUND EXAMINATION RESULT: Result of the ultrasound examination of the axilla. This will normally be the result of the ultrasound examination of the axilla undertaken at the first outpatient appointment at the breast clinic. If the patient attends more than one breast clinic, the result of each ultrasound examination of the axilla should be recorded.

U1	Normal
U2	Benign
U3	Indeterminate/probably benign
U4	Suspicious of malignancy
U5	Highly suspicious of malignancy

2.3 BREAST – CANCER CARE PLAN

To carry cancer care plan details for breast cancer.

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
BR4120	BREAST - CANCER CARE PLAN	**NPI SCORE** *[NOTTINGHAM PROGNOSTIC INDEX SCORE]*	max n2.max n2	M

NPI SCORE: Nottingham Prognostic Index Score (calculated from invasive tumour size, grade and lymph node involvement).

Where:

- **S** is the maximum diameter of the index lesion in centimetres (invasive carcinoma)
- **N** is the number of axillary lymph nodes involved: 0 nodes = 1, 1-3 nodes = 2, >4 = 3
- **G** is the grade of tumour: Grade 1 = 1, Grade 2 = 2, Grade 3 = 3

The index is calculated using the formula:

NPI = [0.2 x S] + N + G

Note: It is important to record all relevant information to ensure that NPI following neoadjuvant therapy can be identified. This includes* NEOADJUVANT THERAPY INDICATOR *in the core pathology section and use of y prefixes if appropriate in TNM stage fields.

2.4 BREAST – SURGERY AND OTHER PROCEDURES

To carry surgery and other procedure details for breast cancer.

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
BR4130	BREAST - SURGERY & OTHER PROCEDURES	**ASA SCORE** *[ASA PHYSICAL STATUS CLASSIFICATION SYSTEM CODE]*	an1	M

ASA SCORE*:* The ASA physical status classification system is a system for assessing the fitness of patients before surgery. You would expect to find this information in the pre-operative notes or the Anaesthetist review section.

1	A normal healthy patient.
2	A patient with mild systemic disease.
3	A patient with severe systemic disease that limits function, but is not incapacitating.
4	A patient with severe systemic disease that is a constant threat to life.
5	A moribund patient who is not expected to survive without the operation.
6	A declared brain-dead patient whose organs are being removed for donor purposes.

2.5 BREAST – STAGING

UICC CLASSIFICATION OF BREAST TNM STAGING, SEVENTH EDITION

Stage Grouping	*T Stage*	*N Stage*	*M Stage*
Stage I	T1	N0	M0
	T0, T1	N1	M0
Stage II	T0, T1	N1	M0
	T2	N0	M0
	T2	N1	M0
	T3	N0	M0
Stage III	T0, T1, T2	N2	M0
	T3	N1, N2	M0
	T4	N0, N1, N2	M0
	Any T	N3	M0
Stage IV	Any T	Any N	M1

Primary Tumour	
Tis	Tumour in situ: DCIS (ductal carcinoma in situ); LCIS (lobular carcinoma in situ)
T1mi	Microinvasion is 0.1cm or less in greatest dimension*
T1a	Tumour is more than 0.1cm but not more than 0.5cm in greatest dimension
T1b	Tumour is more than 0.5cm but not more than 1cm in greatest dimension
T1c	Tumour is more than 1cm but not more than 2cm in greatest dimension
T2	Tumour more than 2cm but not more than 5cm in greatest dimension
T3	Tumour more than 5cm in greatest dimension
T4a	Extension to chest wall does not include pectoralis muscle invasion only)
T4b	Ulceration, ipsilateral satellite skin nodules or skin oedema (including peau d'orange)
T4c	Both T4a and T4b, as above
T4d	Inflammatory carcinoma
Regional Lymph Nodes	
N0	No regional lymph node metastasis
N1	Metastasis in movable ipsilateral Level I,II axillary lymph node(s)
N2a	Metastasis in axillary lymph node(s) fixed to one another (matted) or to other structures
N2b	Metastasis only in clinically detected internal mammary lymph node(s) and in absence of clinically evident axillary lymph node metastasis
N3a	Metastasis in infraclavicular lymph node(s)
N3b	Metastasis in internal mammary and axillary lymph nodes
N3c	Metastasis in supraclavicular lymph node(s)
Distant Metastasis	
M0	No distant metastasis
M1	Distant metastasis

2.6 BREAST – PATHOLOGY

To carry pathology details for breast cancer.

This section can be recorded more than once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
BR4320	BREAST - PATHOLOGY	**INVESTIGATION RESULT DATE**	an10 ccyy-mm-dd	M
BR4330	BREAST - PATHOLOGY	**SERVICE REPORT IDENTIFIER**	max an18	R
BR4140	BREAST - PATHOLOGY	**MULTIFOCAL TUMOUR INDICATOR (BREAST)** *[MULTIFOCAL TUMOUR INDICATOR]*	an1	M
BR4160	BREAST - PATHOLOGY	**DCIS GRADE** *[DUCTAL CARCINOMA IN SITU GRADE]*	an1	R
BR4170	BREAST - PATHOLOGY	**INVASIVE GRADE (BREAST)** *[BREAST INVASIVE GRADE]*	an1	R
BR4180	BREAST - PATHOLOGY	**NON INVASIVE TUMOUR SIZE**	max n3.max n2	R
BR4190	BREAST - PATHOLOGY	**WHOLE TUMOUR SIZE**	max n3.max n2	R
BR4200	BREAST - PATHOLOGY	**METASTASIS EXTENT CODE**	an1	R
BR4210	BREAST - PATHOLOGY	**DISTANCE TO MARGIN**	max n2	R
BR4230	BREAST - PATHOLOGY	**ER ALLRED SCORE** *[ALLRED SCORE (ESTROGEN RECEPTOR)]*	an1	R
BR4220	BREAST - PATHOLOGY	**ER STATUS** *[ESTROGEN RECEPTOR STATUS]*	an1	R
BR4300	BREAST - PATHOLOGY	**PR ALLRED SCORE** *[ALLRED SCORE (PROGESTERONE RECEPTOR)]*	an1	R
BR4290	BREAST - PATHOLOGY	**PR STATUS** *[PROGESTERONE RECEPTOR STATUS]*	an1	R
BR4280	BREAST - PATHOLOGY	**HER2 STATUS** *[HUMAN EPIDERMAL GROWTH FACTOR RECEPTOR STATUS]*	an1	R
BR4310	BREAST - PATHOLOGY	**HER2 ISH STATUS** *[HUMAN EPIDERMAL GROWTH FACTOR IN-SITU HYBRIDIZATION RECEPTOR STATUS]*	an1	R
BR4240	BREAST - PATHOLOGY	**CYTOLOGY (BREAST)** *[CYTOLOGY RESULT CODE (BREAST)]*	an2	R
BR4250	BREAST - PATHOLOGY	**CYTOLOGY (NODE)** *[CYTOLOGY RESULT CODE (NODE)]*	an2	R
BR4260	BREAST - PATHOLOGY	**CORE BIOPSY (BREAST)** *[CORE BIOPSY RESULT CODE (BREAST)]*	max an3	R
BR4270	BREAST - PATHOLOGY	**CORE BIOPSY (NODE)** *[CORE BIOPSY RESULT CODE (NODE)]*	an2	R

INVESTIGATION RESULT DATE: The date on which an investigation was concluded e.g. the date the result was authorised.

SERVICE REPORT IDENTIFIER: A unique identifier of a SERVICE REPORT.

MULTIFOCAL TUMOUR INDICATOR (BREAST)*:* Is there more than one discrete tumour identified in the same breast?

Y	Yes
N	No
9	Not Known

DCIS GRADE: If ductal carcinoma in situ is present, record the DCIS grade. This is the cytonuclear grade.

H	High
I	Intermediate
L	Low
X	Not assessable

INVASIVE GRADE (BREAST): The invasive histological grade of the tumour as defined by modified Bloom and Richardson system.

1	Grade 1
2	Grade 2
3	Grade 3
X	Not assessable

NON INVASIVE TUMOUR SIZE: The size of the non-invasive tumour in mm. This is only required if there is no invasive component.

Note: For COSD reporting purposes, this data item is not required to be submitted to two decimal places.

WHOLE TUMOUR SIZE: Whole size of tumour (invasive + surrounding DCIS, if DCIS extends >1mm beyond invasive) (mm) (For tumours without a DCIS component this will be the same as INVASIVE LESION SIZE).

Note: For COSD reporting purposes, this data item is not required to be submitted to two decimal places.

METASTASIS EXTENT CODE: For single node positivity, specify micrometastatic status as follows: Greater than 2mm = Metastases, 2mm to greater than 0.2mm = Micrometastasis, less than or equal to 0.2mm = Isolated tumour cells.

1	Metastasis
2	Micrometastasis
3	Isolated tumour cells
9	Not known

DISTANCE TO MARGIN: Distance to closest relevant margin (mm). Distance to nearest margin whether invasive or non-invasive.

ER ALLRED SCORE: ER Allred score (range 0, 2 -8)

ER STATUS*:* Oestrogen Receptor (ER) status.

(A positive score means that Estrogen is causing your tumour to grow, and a negative score means that the tumour is not driven by estrogen).

P	Positive
N	Negative
X	Not performed

PR ALLRED SCORE*:* Record the PR ALLRED score if known. (Range 0, 2-8)

PR STATUS*:* Progesterone Receptor Status. Record the PR status if known.

P	Positive

N	Negative
X	Not performed

HER2 STATUS: HER2 Immunohistochemical status (Human Epidermal Growth Factor Receptor 2). Where the initial result of this test is "Borderline", a further report will follow with result of the ISH test.

P	Positive
N	Negative
B	Borderline
X	Not performed

HER2 ISH STATUS*:* Record the result of the ISH (in-situ hybridization) test. This is only required if the initial HER2 status is "Borderline".

P	Positive
N	Negative

CYTOLOGY (BREAST)*:* Cytology opinion (Breast)

C1	Inadequate/unsatisfactory specimen
C2	Benign
C3	Uncertain
C4	Suspicious of malignancy
C5	Malignant

CYTOLOGY (NODE)*:* Cytology opinion on axillary lymph node.

C1	Inadequate/unsatisfactory specimen
C2	Benign
C3	Uncertain
C4	Suspicious of malignancy
C5	Malignant

CORE BIOPSY (BREAST)*:* Needle core biopsy opinion.

B1	Normal
B2	Benign
B3	Uncertain malignant potential
B4	Suspicious
B5a	Malignant (In situ)
B5b	Malignant (Invasive)
B5c	Malignant (Not assessable)

CORE BIOPSY (NODE)*:* Needle biopsy opinion on axillary lymph node.

B1	Normal
B2	Benign
B3	Uncertain malignant potential
B4	Suspicious
B5	Malignant

3. CENTRAL NERVOUS SYSTEM (CNS)

OVERVIEW

For the COSD benign brain cancers are included in the Central Nervous System Dataset, although they are excluded from Cancer Waits.

ICD-10 codes C47 and C69 are grouped under Brain/Central Nervous System for Cancer Waits but are excluded from the COSD Central Nervous System dataset. For diseases coded under C47 (peripheral nerves and autonomic nervous system) or C69 (eye and adnexa) only the CORE dataset needs to be completed.

TNM Staging does not need to be collected for CNS cancers.

ICD-10 CODES

Note: That for Central Nervous System full details are required for benign and uncertain tumours as well as malignant diseases.

Key:
() = if applicable
* = different dataset from CWT group specified

ICD-10 All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C47.0	*Peripheral nerves of head, face and neck*	*Brain/Central Nervous System*		●		*Usually treated by Sarcoma MDT.*
C47.1	*Peripheral nerves of upper limb, including shoulder*	*Brain/Central Nervous System*		●		*Usually treated by Sarcoma MDT.*
C47.2	*Peripheral nerves of lower limb, including hip*	*Brain/Central Nervous System*		●		*Usually treated by Sarcoma MDT.*
C47.3	*Peripheral nerves of thorax*	*Brain/Central Nervous System*		●		*Usually treated by Sarcoma MDT.*
C47.4	*Peripheral nerves of abdomen*	*Brain/Central Nervous System*		●		*Usually treated by Sarcoma MDT.*
C47.5	*Peripheral nerves of pelvis*	*Brain/Central Nervous System*		●		*Usually treated by Sarcoma MDT.*
C47.6	*Peripheral nerves of trunk, unspecified*	*Brain/Central Nervous System*		●		*Usually treated by Sarcoma MDT.*

C47.8	*Overlapping lesion of peripheral nerves and autonomic nervous system*	*Brain/Central Nervous System*		●		*Usually treated by Sarcoma MDT.*
C47.9	*Peripheral nerves and autonomic nervous system, unspecified*	*Brain/Central Nervous System*		●		*Usually treated by Sarcoma MDT.*
C69.0	*Conjunctiva*	*Brain/Central Nervous System*		●		*Not normally treated by CNS MDT.*
C69.1	*Cornea*	*Brain/Central Nervous System*		●		*Not normally treated by CNS MDT.*
C69.2	*Retina*	*Brain/Central Nervous System*		●		*Not normally treated by CNS MDT.*
C69.3	*Choroid*	*Brain/Central Nervous System*		●		*Not normally treated by CNS MDT.*
C69.4	*Ciliary body*	*Brain/Central Nervous System*		●		*Not normally treated by CNS MDT.*
C69.5	*Lachrymal gland and duct*	*Brain/Central Nervous System*		●		*Not normally treated by CNS MDT.*
C69.6	*Orbit*	*Brain/Central Nervous System*		●		*Not normally treated by CNS MDT. Maybe treated by Sarcoma MDT.*
C69.8	*Overlapping lesion of eye and adnexa*	*Brain/Central Nervous System*		●		*Not normally treated by CNS MDT.*
C69.9	*Eye, unspecified*	*Brain/Central Nervous System*		●		*Not normally treated by CNS MDT.*
C70.0	Cerebral meninges	Brain/Central Nervous System	●			
C70.1	Spinal meninges	Brain/Central Nervous System	●			
C70.9	Meninges, unspecified	Brain/Central Nervous System	●			
C71.0	Cerebrum, except lobes and ventricles	Brain/Central Nervous System	●			
C71.1	Frontal lobe	Brain/Central Nervous System	●			

C71.2	Temporal lobe	Brain/Central Nervous System	●			
C71.3	Parietal lobe	Brain/Central Nervous System	●			
C71.4	Occipital lobe	Brain/Central Nervous System	●			
C71.5	Cerebral ventricle	Brain/Central Nervous System	●			
C71.6	Cerebellum	Brain/Central Nervous System	(●) (*)			CTYA dataset collected for Meduloblastoma patients under 25.
C71.7	Brain stem	Brain/Central Nervous System	●			
C71.8	Overlapping lesion of brain	Brain/Central Nervous System	●			
C71.9	Brain, unspecified	Brain/Central Nervous System	●			
C72.0	Spinal cord	Brain/Central Nervous System	●			
C72.1	Cauda equina	Brain/Central Nervous System	●			
C72.2	Olfactory nerve	Brain/Central Nervous System	●			
C72.3	Optic nerve	Brain/Central Nervous System	●			
C72.4	Acoustic nerve	Brain/Central Nervous System	●			
C72.5	Other and unspecified cranial nerves	Brain/Central Nervous System	●			
C72.8	Overlapping lesion of brain and other parts of central nervous system	Brain/Central Nervous System	●			
C72.9	Central nervous system, unspecified	Brain/Central Nervous System	●			
C75.1	Pituitary gland	Other	*			Usually treated by CNS MDT.

C75.2	Craniopharyngeal duct	Other	*			Usually treated by CNS MDT.
C75.3	Pineal gland	Other	*			Usually treated by CNS MDT.
C79.3	Secondary malignant neoplasm of brain and cerebral meninges	Brain/Central Nervous System		●		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
C79.4	Secondary malignant neoplasm of other and unspecified parts of nervous system	Brain/Central Nervous System		●		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
D32.0	benign neoplasm of cerebral meninges	Brain/Central Nervous System	●			
D32.1	benign neoplasm of spinal meninges	Brain/Central Nervous System	●			
D32.9	benign neoplasm of meninges, unspecified	Brain/Central Nervous System	●			
D33.0	Benign neoplasm of brain, supratentorial	Brain/Central Nervous System	●			
D33.1	Benign neoplasm of brain, infratentorial	Brain/Central Nervous System	●			
D33.2	Benign neoplasm of brain, unspecified	Brain/Central Nervous System	●			
D33.3	Benign neoplasm of cranial nerves	Brain/Central Nervous System	●			
D33.4	Benign neoplasm of spinal cord	Brain/Central Nervous System	●			
D33.7	Benign neoplasm of other specified parts of central nervous system	Brain/Central Nervous System	●			
D33.9	Benign neoplasm of central nervous system, unspecified	Brain/Central Nervous System	●			
D35.2	Benign neoplasm of Pituitary gland	Brain/Central Nervous System	●			

D35.3	Benign neoplasm of Craniopharyngeal duct	Other	*			Usually treated by CNS MDT.
D35.4	Benign neoplasm of Pineal gland	Brain/Central Nervous System	●			
D42.0	Neoplasm of uncertain or unknown behaviour of cerebral meninges	Brain/Central Nervous System	●			
D42.1	Neoplasm of uncertain or unknown behaviour of spinal meninges	Brain/Central Nervous System	●			
D42.9	Neoplasm of uncertain or unknown behaviour of meninges, unspecified	Brain/Central Nervous System	●			
D43.0	Neoplasm of uncertain or unknown behaviour of brain, supratentorial	Brain/Central Nervous System	●			
D43.1	Neoplasm of uncertain or unknown behaviour of brain, infratentorial	Brain/Central Nervous System	●			
D43.2	Neoplasm of uncertain or unknown behaviour of brain, unspecified	Brain/Central Nervous System	●			
D43.3	Neoplasm of uncertain or unknown behaviour of cranial nerves	Brain/Central Nervous System	●			
D43.4	Neoplasm of uncertain or unknown behaviour of spinal cord	Brain/Central Nervous System	●			
D43.7	Neoplasm of uncertain or unknown behaviour of other parts of central nervous system	Brain/Central Nervous System	●			

D43.9	Neoplasm of uncertain or unknown behaviour of central nervous system, unspecified	Brain/Central Nervous System	●			
D44.3	Neoplasm of uncertain or unknown behaviour of pituitary gland	Brain/Central Nervous System	●			
D44.4	Neoplasm of uncertain or unknown behaviour of Craniopharyngeal duct	Brain/Central Nervous System	●			
D44 .5	Neoplasm of uncertain or unknown behaviour of pineal gland	Brain/Central Nervous System	●			

3.1 CENTRAL NERVOUS SYSTEM – IMAGING

To carry imaging details for Central Nervous System cancer.
This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
BA3000	CENTRAL NERVOUS SYSTEM - IMAGING	**LESION LOCATION (RADIOLOGICAL)**	an2	R
BA3020	CENTRAL NERVOUS SYSTEM - IMAGING	**NUMBER OF LESIONS (RADIOLOGICAL)**	max n2	R
BA3030	CENTRAL NERVOUS SYSTEM - IMAGING	**LESION SIZE (RADIOLOGICAL)**	max n3.max n2	R
Start of repeating item - Features of Lesions (Radiological)				
BA3040	CENTRAL NERVOUS SYSTEM - IMAGING	**FEATURES OF LARGEST LESION (RADIOLOGICAL)** *[LARGEST LESION FEATURES (RADIOLOGICAL)]*	an2	R
End of repeating item - Features of Lesions (Radiological)				
BA3050	CENTRAL NERVOUS SYSTEM - IMAGING	**PRINCIPAL DIAGNOSTIC IMAGING TYPE**	an1	R

LESION LOCATION (RADIOLOGICAL): Radiologically determined anatomical location of lesion (largest lesion if more than one) or where centred. This is recorded prior to treatment.

01	Frontal lobe

02	Temporal lobe
03	Parietal lobe
04	Occipital lobe
05	Pineal region
06	Hypothalamic
07	Basal ganglia/thalamic
08	Cerebellar
09	Midbrain
10	Pons
11	Medulla
12	Fourth ventricle
13	Third ventricle
14	Lateral ventricle
15	Parasagittal/parafalcine dura
16	Posterior fossa convexity dura
17	Convexity dura
18	Petrous temporal bone
19	Orbital roof
20	Skull vault
21	Scalp
22	Anterior cranial fossa
23	Middle cranial fossa
25	Infratemporal fossa
26	Pterygopalatine fossa
27	Anterior clinoid dura
28	Sphenoid wing dura
29	Subfrontal dura
30	Suprasellar dura
31	Clival dura
32	Cavernous sinus
33	Cerebellopontine angle
34	Jugular bulb
35	Venous angle dura
36	Foramen magnum
37	Cervical intramedullary
38	Cervical intradural
39	Cervical extradural
40	Cervical bony
41	Thoracic intramedullary
42	Thoracic intradural
43	Thoracic extradural
44	Thoracic bony
45	Lumbar intramedullary
46	Lumbar intradural
47	Lumbar extradural
48	Lumbar bony

98	Other

NUMBER OF LESIONS (RADIOLOGICAL): Radiologically determined number of lesions.

LESION SIZE (RADIOLOGICAL): Radiological estimate in millimetres (mm) of the maximum diameter of the tumour measured prior to treatment (largest lesion if more than one). Record as "0" to indicate not assessable for diffuse tumours (e.g. gliomatosis cerebri).

Note: For COSD reporting purposes, this data item is not required to be submitted to two decimal places.

FEATURES OF LARGEST LESION (RADIOLOGICAL): Radiologically identified features of the largest lesion such as density, necrosis recorded pre-treatment. This may involve selection of more than one value.

01	Contrast-enhancement
02	Calcification
03	Mass effect
04	Hydrocephalus
05	Haemorrhage
06	Cystic/multi-cystic
07	Dural tail
08	Brain oedema
09	Cord signal change
10	Cord compression

PRINCIPAL DIAGNOSTIC IMAGING TYPE: Indicate the principal imaging procedure undertaken to diagnose the tumour.

Please note that the value PET Scan includes PET-CT Scan.

1	CT Scan
2	MRI Scan
3	PET Scan

3.2 CENTRAL NERVOUS SYSTEM – CANCER CARE PLAN

To carry cancer care plan details for Central Nervous System cancer.
This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
BA3060	CENTRAL NERVOUS SYSTEM - CANCER CARE PLAN	**PRIMARY DIAGNOSIS (ICD RADIOLOGICAL)**	an6	R
BA3080	CENTRAL NERVOUS SYSTEM - CANCER CARE PLAN	**MDT PROVISIONAL DIAGNOSIS (ICD)** *[PROVISIONAL DIAGNOSIS (ICD)]*	an6	M

PRIMARY DIAGNOSIS (ICD RADIOLOGICAL): Primary diagnosis based on imaging. In many cases this will be the definitive clinical diagnosis, but needs to be distinguished from the subsequent pathological diagnosis - if it becomes available. You may be able to identify this information at the MDT meeting during the imaging review.

ICD-10

MDT PROVISIONAL DIAGNOSIS (ICD): Working diagnosis as defined at MDT where the first definitive treatment is agreed. This is the clinical opinion which may also be informed by biopsy, radiological and/or other investigations.

ICD-10

3.3 CENTRAL NERVOUS SYSTEM – SURGERY & OTHER PROCEDURES

To carry surgery and other procedure details for Central Nervous System cancer.
This section will be recorded once per treatment.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
BA3130	CENTRAL NERVOUS SYSTEM - SURGERY & OTHER PROCEDURES	**ASA SCORE** *[ASA PHYSICAL STATUS CLASSIFICATION SYSTEM CODE]*	an1	R
BA3100	CENTRAL NERVOUS SYSTEM - SURGERY & OTHER PROCEDURES	**TUMOUR LOCATION (SURGICAL)**	an2	R
BA3140	CENTRAL NERVOUS SYSTEM - SURGERY & OTHER PROCEDURES	**EXCISION TYPE**	an1	R

ASA SCORE *[ASA PHYSICAL STATUS CLASSIFICATION SYSTEM CODE]:* The ASA physical status classification system is a system for assessing the fitness of patients before surgery.

1	A normal healthy patient.
2	A patient with mild systemic disease.
3	A patient with severe systemic disease that limits function, but is not incapacitating.
4	A patient with severe systemic disease that is a constant threat to life.
5	A moribund patient who is not expected to survive without the operation.
6	A declared brain-dead patient whose organs are being removed for donor purposes.

TUMOUR LOCATION (SURGICAL): Surgically determined anatomical location of lesion(s) or where centred.

01	Frontal lobe	26	Pterygopalatine fossa
02	Temporal lobe	27	Anterior clinoid dura
03	Parietal lobe	28	Sphenoid wing dura
04	Occipital lobe	29	Subfrontal dura
05	Pineal region	30	Suprasellar dura
06	Hypothalamic	31	Clival dura
07	Basal ganglia/thalamic	32	Cavernous sinus
08	Cerebellar	33	Cerebellopontine angle
09	Midbrain	34	Jugular bulb
10	Pons	35	Venous angle dura
11	Medulla	36	Foramen magnum
12	Fourth ventricle	37	Cervical intramedullary
13	Third ventricle	38	Cervical intradural

14	Lateral ventricle	39	Cervical extradural
15	Parasagittal/parafalcine dura	40	Cervical bony
16	Posterior fossa convexity dura	41	Thoracic intramedullary
17	Convexity dura	42	Thoracic intradural
18	Petrous temporal bone	43	Thoracic extradural
19	Orbital roof	44	Thoracic bony
20	Skull vault	45	Lumbar intramedullary
21	Scalp	46	Lumbar intradural
22	Anterior cranial fossa	47	Lumbar extradural
23	Middle cranial fossa	48	Lumbar bony
25	Infratemporal fossa	98	Other

EXCISION TYPE: Identify whether excision is Partial or Total

P	Partial
T	Total macroscopic
U	Extent uncertain

3.4 CENTRAL NERVOUS SYSTEM – RADIOSURGERY

To carry radiosurgery details for Central Nervous System cancer.
This section will be recorded once per treatment where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
BA3110	CENTRAL NERVOUS SYSTEM - RADIOSURGERY	**RADIOSURGERY PERFORMED INDICATOR**	an1	M
BA3120	CENTRAL NERVOUS SYSTEM - RADIOSURGERY	**PROCEDURE DATE (RADIOSURGERY)**	an10 ccyy-mm-dd	R

RADIOSURGERY PERFORMED INDICATOR: Did patient have radiosurgical treatment. This information only needs to be collected by the specialist centre where the radiosurgery was performed.

Y	Yes
N	No
9	Not known

PROCEDURE DATE (RADIOSURGERY): Date of radiosurgical treatment. This information only needs to be collected by the specialist centre where the radiosurgery was performed.

3.5 CENTRAL NERVOUS SYSTEM – PATHOLOGY

To carry pathology details for Central Nervous System cancer.
This section can be recorded more than once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
BA3170	CENTRAL NERVOUS SYSTEM - PATHOLOGY	**INVESTIGATION RESULT DATE**	an10 ccyy-mm-dd	M
BA3180	CENTRAL NERVOUS SYSTEM - PATHOLOGY	**SERVICE REPORT IDENTIFIER**	max an18	R
Start of repeating item - Molecular Diagnostics Code				
BA3070	CENTRAL NERVOUS SYSTEM - PATHOLOGY	**MOLECULAR DIAGNOSTICS CODE**	an1	R
End of repeating item - Molecular Diagnostics Code				
Start of repeating item - Immunohistochemistry Hormone Expression Type				
BA3150	CENTRAL NERVOUS SYSTEM - PATHOLOGY	**IMMUNOHISTOCHEMISTRY HORMONE EXPRESSION TYPE** *[HORMONE EXPRESSION TYPE]*	an1	R
End of repeating item - Immunohistochemistry Hormone Expression Type				
BA3160	CENTRAL NERVOUS SYSTEM - PATHOLOGY	**WHO TUMOUR GRADE (CNS)** *[WORLD HEALTH ORGANISATION CENTRAL NERVOUS SYSTEM TUMOUR GRADE]*	an1	R

INVESTIGATION RESULT DATE: The date on which an investigation was concluded e.g. the date the result was authorised.

SERVICE REPORT IDENTIFIER: A unique identifier of a SERVICE REPORT.

MOLECULAR DIAGNOSTICS CODE: Chromosomal or genetic markers associated with the brain tumour. This may involve selection of more than one value for each tumour.

1	Evidence of IDH1 or IDH2 mutation
2	Evidence of methylation of the MGMT gene CpG island
3	Evidence of total loss of 1p and 19q
4	Evidence of KIAA 1549-BRAF fusion gene
5	Other

IMMUNOHISTOCHEMISTRY HORMONE EXPRESSION TYPE *[HORMONE EXPRESSION TYPE]:* Hormone expression by immunohistochemistry. FOR PITUITARY ADENOMAS ONLY. (Multiple values may be recorded)

0	Non functioning
1	ACTH
2	LH
3	FSH
4	Alpha-subunit
5	TSH
6	Prolactin
7	Growth Hormone

WHO TUMOUR GRADE (CNS) [WORLD HEALTH ORGANISATION CENTRAL NERVOUS SYSTEM TUMOUR GRADE]: The grade of the tumour using WHO classification for tumours of the central nervous system. FOR INTRA AXIAL AND EXTRA AXIAL ONLY.

1	I
2	II
3	III
4	IV

4. COLORECTAL

OVERVIEW

TNM Staging needs to be collected for Colorectal cancers. Please note that there are different editions of TNM Stage used for different disease sites (see section 4.4 Colorectal – Staging).

Site specific data items have been aligned between the COSD and the National Bowel Cancer Audit.

ICD-10 CODES

Key:

() = if applicable

* = different dataset from CWT group specified

ICD-10 All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C17.0	*Duodenum*	*Colorectal*		●		*Usually treated by Upper GI MDT*
C17.1	*Jejunum*	*Colorectal*		●		*Usually treated by Upper GI MDT*
C17.2	*Ileum*	*Colorectal*		●		*Usually treated by Upper GI MDT*
C17.3	*Meckel's diverticulum*	*Colorectal*		●		*Usually treated by Upper GI MDT*
C17.8	*Overlapping lesion of small intestine*	*Colorectal*		●		*Usually treated by Upper GI MDT*
C17.9	*Small intestine, unspecified*	*Colorectal*		●		*Usually treated by Upper GI MDT*
C18.0	Caecum	Colorectal	●			
C18.1	Appendix	Colorectal		●		
C18.2	Ascending colon	Colorectal	●			
C18.3	Hepatic flexure	Colorectal	●			
C18.4	Transverse colon	Colorectal	●			
C18.5	Splenic flexure	Colorectal	●			
C18.6	Descending colon	Colorectal	●			
C18.7	Sigmoid colon	Colorectal	●			

C18.8	Overlapping lesion of colon	Colorectal	●			
C18.9	Colon, unspecified	Colorectal	●			
C19	Malignant neoplasm of rectosigmoid junction	Colorectal	●			
C20	Malignant neoplasm of rectum	Colorectal	●			
C21.0	Anus, unspecified	Colorectal		●		
C21.1	Anal canal	Colorectal		●		
C21.2	Cloacogenic zone	Colorectal		●		
C21.8	Overlapping lesion of rectum, anus and anal canal	Colorectal		●		
C26.0	Intestinal tract, part unspecified	Colorectal	●			
C26.1	Spleen	Colorectal		●		
C26.8	Overlapping lesion of digestive system	Colorectal		●		
C26.9	Ill-defined sites within the digestive system	Colorectal		●		
C78.4	Secondary malignant neoplasm of small intestine	Colorectal		●		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
C78.5	Secondary malignant neoplasm of large intestine and rectum	Colorectal		●		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
C78.8	Secondary malignant neoplasm of other and unspecified digestive organs	Colorectal		●		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.

D01.0	Carcinoma in situ of Colon	Colorectal			●	
D01.1	Carcinoma in situ of Rectosigmoid junction	Colorectal			●	
D01.2	Carcinoma in situ of Rectum	Colorectal			●	
D01.3	Carcinoma in situ of Anus and anal canal	Colorectal			●	
D01.4	Carcinoma in situ of Anus and anal canal	Colorectal			●	
D01.7	Other specified digestive organs	Colorectal			●	
D01.9	Carcinoma in situ of Digestive organ, unspecified	Colorectal			●	
D37.3	Neoplasm of uncertain or unknown behaviour of Appendix	Colorectal			●	
D37.4	Neoplasm of uncertain or unknown behaviour of Colon	Colorectal			●	
D37.5	Neoplasm of uncertain or unknown behaviour of Rectum	Colorectal			●	
D37.7	Other digestive organs	Colorectal/Upper Gastrointestinal			●	
D37.9	Digestive organ, unspecified	Colorectal/Upper Gastrointestinal			●	

4.1 COLORECTAL – IMAGING

To carry imaging details for colorectal cancer. The following data items may be collected through the DIDS. This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CO5010	COLORECTAL - IMAGING	**PROCEDURE DATE (FIRST CT SCAN)** *[PROCEDURE DATE (CT SCAN)]*	an10 ccyy-mm-dd	R
CO5020	COLORECTAL - IMAGING	**PROCEDURE DATE (FIRST MRI SCAN OF RECTUM)** *[PROCEDURE DATE (FIRST MRI SCAN)]*	an10 ccyy-mm-dd	R

CO5030	COLORECTAL - IMAGING	**PROCEDURE DATE (SECOND MRI SCAN OF RECTUM)** *[PROCEDURE DATE (SECOND MRI SCAN)]*	an10 ccyy-mm-dd	R
CO5040	COLORECTAL - IMAGING	**DATE OF ENDOANAL ULTRASOUND** *[PROCEDURE DATE (ENDOANAL ULTRASOUND)]*	an10 ccyy-mm-dd	R

PROCEDURE DATE (FIRST CT SCAN)*:* Record the date on which the first staging CT was performed.

PROCEDURE DATE (FIRST MRI SCAN OF RECTUM)*:* RECTAL CANCERS ONLY. Date of first MRI scan of rectum pre-treatment.

PROCEDURE DATE (SECOND MRI SCAN OF RECTUM)*:* RECTAL CANCERS ONLY. Date of MRI scan of rectum following neo adjuvant treatment and before surgical treatment, if performed.

DATE OF ENDOANAL ULTRASOUND*:* RECTAL CANCERS ONLY. Date of first pre-operative endoscopic ultrasound. If endoanal ultrasound performed then date must be specified.

4.2 COLORECTAL – DIAGNOSIS

To carry diagnosis details for colorectal cancer.
This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CO5060	COLORECTAL - DIAGNOSIS	**SYNCHRONOUS TUMOUR INDICATOR (CAECUM)**	an1	R
CO5070	COLORECTAL - DIAGNOSIS	**SYNCHRONOUS TUMOUR INDICATOR (APPENDIX)**	an1	R
CO5080	COLORECTAL - DIAGNOSIS	**SYNCHRONOUS TUMOUR INDICATOR (ASCENDING COLON)**	an1	R
CO5090	COLORECTAL - DIAGNOSIS	**SYNCHRONOUS TUMOUR INDICATOR (HEPATIC FLEXURE)**	an1	R
CO5100	COLORECTAL - DIAGNOSIS	**SYNCHRONOUS TUMOUR INDICATOR (TRANSVERSE COLON)**	an1	R
CO5110	COLORECTAL - DIAGNOSIS	**SYNCHRONOUS TUMOUR INDICATOR (SPLENIC FLEXURE)**	an1	R
CO5120	COLORECTAL - DIAGNOSIS	**SYNCHRONOUS TUMOUR INDICATOR (DESCENDING COLON)**	an1	R
CO5130	COLORECTAL - DIAGNOSIS	**SYNCHRONOUS TUMOUR INDICATOR (SIGMOID COLON)**	an1	R
CO5140	COLORECTAL - DIAGNOSIS	**SYNCHRONOUS TUMOUR INDICATOR (RECTOSIGMOID)**	an1	R
CO5150	COLORECTAL - DIAGNOSIS	**SYNCHRONOUS TUMOUR INDICATOR (RECTUM)**	an1	R
CO5160	COLORECTAL - DIAGNOSIS	**TUMOUR HEIGHT ABOVE ANAL VERGE**	max n2	R

SYNCHRONOUS TUMOUR INDICATOR (CAECUM): Record any synchronous tumours in the Caecum as identified by the clinician at presentation. Synchronous tumours are defined as discrete tumours apparently

not in continuity with other primary cancers originating in the same site or tissue. Note: If 'Yes' a separate registration is required.

Y	Yes
N	No

SYNCHRONOUS TUMOUR INDICATOR (APPENDIX): Record any synchronous tumours in the Appendix as identified by the clinician at presentation. Synchronous tumours are defined as discrete tumours apparently not in continuity with other primary cancers originating in the same site or tissue. Note: If 'Yes' a separate registration is required.

Y	Yes
N	No

SYNCHRONOUS TUMOUR INDICATOR (ASCENDING COLON): Record any synchronous tumours in the Ascending Colon as identified by the clinician at presentation. Synchronous tumours are defined as discrete tumours apparently not in continuity with other primary cancers originating in the same site or tissue. Note: If 'Yes' a separate registration is required.

Y	Yes
N	No

SYNCHRONOUS TUMOUR INDICATOR (HEPATIC FLEXURE): Record any synchronous tumours in the Hepatic Flexure as identified by the clinician at presentation. Synchronous tumours are defined as discrete tumours apparently not in continuity with other primary cancers originating in the same site or tissue. Note: If 'Yes' a separate registration is required.

Y	Yes
N	No

SYNCHRONOUS TUMOUR INDICATOR (TRANSVERSE COLON): Record any synchronous tumours in the Transverse Colon as identified by the clinician at presentation. Synchronous tumours are defined as discrete tumours apparently not in continuity with other primary cancers originating in the same site or tissue. Note: If 'Yes' a separate registration is required.

Y	Yes
N	No

SYNCHRONOUS TUMOUR INDICATOR (SPLENIC FLEXURE): Record any synchronous tumours in the Splenic Flexure as identified by the clinician at presentation. Synchronous tumours are defined as discrete tumours apparently not in continuity with other primary cancers originating in the same site or tissue. Note: If 'Yes' a separate registration is required.

Y	Yes
N	No

SYNCHRONOUS TUMOUR INDICATOR (DESCENDING COLON): Record any synchronous tumours in the Descending Colon as identified by the clinician at presentation. Synchronous tumours are defined as discrete tumours apparently not in continuity with other primary cancers originating in the same site or tissue.

Y	Yes
N	No

SYNCHRONOUS TUMOUR INDICATOR (SIGMOID COLON): Record any synchronous tumours in the Sigmoid Colon as identified by the clinician at presentation. Synchronous tumours are defined as discrete tumours

apparently not in continuity with other primary cancers originating in the same site or tissue. Note: If 'Yes' a separate registration is required.

Y	Yes
N	No

SYNCHRONOUS TUMOUR INDICATOR (RECTOSIGMOID): Record any synchronous tumours in the RectoSigmoid as identified by the clinician at presentation. Synchronous tumours are defined as discrete tumours apparently not in continuity with other primary cancers originating in the same site or tissue. Note: If 'Yes' a separate registration is required.

Y	Yes
N	No

SYNCHRONOUS TUMOUR INDICATOR (RECTUM): Record any synchronous tumours in the Rectum as identified by the clinician at presentation. Synchronous tumours are defined as discrete tumours apparently not in continuity with other primary cancers originating in the same site or tissue. Note: If 'Yes' a separate registration is required.

Y	Yes
N	No

TUMOUR HEIGHT ABOVE ANAL VERGE: Record the approximate height in centimetres of the lower limit of the tumour above anal verge as measured by rigid sigmoidoscopy only.

4.3 COLORECTAL - CANCER CARE PLAN

To carry cancer care plan details for colorectal cancer.
This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CO5005	COLORECTAL - CANCER CARE PLAN	**BODY MASS INDEX**	n2.n1	R

BODY MASS INDEX: Estimate of a patient's Body Mass Index (BMI) at diagnosis. The Body Mass Index (BMI) can be derived by a calculation using the patient's height and weight. This data item would be obtained at presentation either in the outpatient clinic or on the ward.

PERSON OBSERVATION (BMI)

4.4 COLORECTAL – STAGING

UICC TNM CLASSIFICATION OF COLORECTAL TUMOURS, FIFTH EDITION – PATHOLOGY

Primary Tumour	
pTX	Primary tumour cannot be assessed
pT0	No evidence of primary tumour
pT1	Tumour invades submucosa
pT2	Tumour invades muscularis propria
pT3	Tumour invades through muscularis propria into subserosa or non-peritonealised pericolic or perirectal

	tissues
pT4	Tumour directly invades other organs (pT4a) and/or involves the visceral peritoneum (pT4b)
Regional Lymph Nodes	
pNX	Regional lymph nodes cannot be assessed
pN0	No regional lymph node metastasis
pN1	Metastasis in 1 to 3 regional lymph nodes
pN2	Metastasis in 4 or more regional lymph nodes
Distant Metastasis	
pMX	Distant metastasis cannot be assessed
pM0	No distant metastasis
pM1	Distant metastasis

UICC TNM CLASSIFICATION OF APPENDIX, SEVENTH EDITION – CARCINOMA TUMOURS

Note: Stage data items for Appendix are not collected by NBOCAP.

Primary Tumour	
T1	Tumour invades submucosa
T2	Tumour invades muscluaria propria
T3	Tumour invades subserosa or mesoappendix
T4	Tumour perforates visceral peritoneum, including mucinous peritoneal tumour within the right lower quadrant and/or directly invades other organs or structures*
T4a	Tumour perforates visceral peritoneum, including mucinous peritoneal tumour within the right lower quardrant
T4b	Tumour directly invades other organs or structures.*

Please note Direct invasion in T4 includes invasion of other intestinal segments by way of the serosa, e.g., invasion of ileum.

Tumour that is adherent to other organs or structures, macroscopically, is classified T4b. However, if no tumour is present in the adhesion, microscopically, the classification should be pT1,2 or 3

Regional Lymph Nodes	
N0	No regional lymph nodes metastasis
N1	Metastasis in 1-3 regional lymph nodes
N2	Metastasis in 4 or more regional lymph nodes

Note: A satellite peritumoural nodule in the periappendiceal adipose tissue of a primary carcinoma without histological evidence of residual lymph nodule may represent discontinuous spread (T3), venous invasion with extravascular spread (T3, V1/2) or a totally replaced lymph node (N1/2)

Distant Metastasis	
M0	No distant
M1	Distant metastasis
M1a	Intraperitonel metastasis beyond the right lower quadrant, including pseudomyxoma peritone
M1b	Non-peritoneal metastasis

UICC TNM CLASSIFICATION OF ANAL, SEVENTH EDITION

Note: Stage data items for Anal cancers are not collected by NBOCAP.

Primary Tumour

T0	Carcinoma in situ, Bowen disease, High-grade Squamous Intraepithelial Lesion (HSIL), Anal Intraepithelial Neoplasia II-III (AIN II-III)
T1	Tumour 2cm or less in greatest dimension
T2	Tumour more than 2cm but no more than 5cm in greatest dimension
T3	Tumour more than 5cmin greatest dimension
T4	Tumour of any size invades adjacent organ(s) e.g. vagina, urethra, bladder
Regional Lymph Nodes	
N0	No regional lymph node metastasis
N1	Metastasis in perirectal lymph node(s)
N2	Metastasis in unilateral internal iliac and/or unilateral inguinal lymph nodes(s)
N3	Metastasis in perirectal and inguinal lymph nodes and/or bilateral internal iliac and/or bilateral inguinal lymph nodes
Distant Metastasis	
M0	No distant metastasis
M1	Distant metastasis

To carry staging details for colorectal cancer.

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CO5170	COLORECTAL - STAGING	**MODIFIED DUKES** *[MODIFIED DUKES CLASSIFICATION CODE]*	max an2	R

MODIFIED DUKES [MODIFIED DUKES CLASSIFICATION CODE]: Dukes' stage of disease at diagnosis (based on pathological evidence but upgraded to Stage D if there is clinical evidence of metastasis). Stage "D" should be recorded if metastatic spread is identified either in the preoperative staging process, e.g. on CT scanning, MRI, USS, chest x-ray or at the time of operation. It is accepted that a small number of "D" cases are cured by further treatment such as liver resection, but for COSD metastatic spread distant from the primary should always be recorded as "D".

A	Dukes A Tumour confined to wall of bowel, nodes negative
B	Dukes B Tumour penetrates through the muscularis propria to involve extramural tissues, nodes negative
C1	Dukes C1 Metastases confined to regional lymph nodes (node/s positive but apical node negative)
C2	Dukes C2 Metastases present in nodes at mesenteric artery ligature (apical node positive)
D	Dukes D Metastatic spread outside the operative field
99	Not known

Note: Recording stage following neoadjuvant therapy

For cases of rectal cancer, particular problems will be encountered where neoadjuvant therapy is used. As with other cases the modified Dukes' stage will be dependent on histological examination of the resected specimen together with information obtained from radiological imaging etc. There is no way of indicating, using modified Dukes' stage alone whether a patient has had neoadjuvant therapy although this can be identified from the NEOADJUVANT THERAPY INDICATOR and from the dates of treatments recorded. Wherever possible TNM with the "y" prefix should be used for pathology stage fields. For resected cases, where there has been a complete pathological response, a modified Dukes' stage

can't be used. Similarly for those cases where no surgery is undertaken a modified Dukes' stage can only be used where metastatic spread has been identified and hence allocated to Modified Dukes' stage "D". For all other cases, where no operation is performed, staging will have to be based on radiological appearances either before or after the neo-adjuvant treatment and an integrated TNM stage decided based on the radiological appearances.

4.5 COLORECTAL - SURGERY & OTHER PROCEDURES

To carry details of surgery and other procedures for each surgery for colorectal cancer.
This section will be recorded once per treatment where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CO5180	COLORECTAL - SURGERY & OTHER PROCEDURES	**SURGICAL ACCESS** *[SURGICAL ACCESS TYPE]*	an1	R

SURGICAL ACCESS: Approach to surgery (laparoscopic, open or converted). Record the access used to perform the operation. Recording the surgical access is standard clinical practice and should be obtained from the operational notes.
'Open operation': Excision of the tumour via a laparotomy with no use of a laparoscope.
'Laparoscopic with planned conversion to open surgery': Excision of the tumour after targeted laparoscopic assessment and/or part of the treatment being completed laparoscopically.
'Laparoscopy with unplanned conversion to open surgery': Inability to complete the intra-abdominal dissection laparoscopically, usually but not always requires the use of a larger incision than that required to extract the specimen.
'Laparoscopic completed': Laparoscopic dissection with small incision to extract the specimen.

1	Open operation
2	Laparoscopic with planned conversion to open surgery
3	Laparoscopic with unplanned conversion to open surgery
4	Laparoscopic completed

4.6 COLORECTAL – PATHOLOGY

To carry details of pathology for colorectal cancer.
This section can be recorded more than once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CO5320	COLORECTAL - PATHOLOGY	**INVESTIGATION RESULT DATE**	an10 ccyy-mm-dd	M
CO5330	COLORECTAL - PATHOLOGY	**SERVICE REPORT IDENTIFIER**	max an18	R

CO5190	COLORECTAL - PATHOLOGY	**POSITIVE PROXIMAL OR DISTAL RESECTION MARGIN** *[MARGIN INVOLVED INDICATION CODE (POSITIVE PROXIMAL OR DISTAL RESECTION MARGIN)]*	an1	R
CO5210	COLORECTAL - PATHOLOGY	**DISTANCE TO CIRCUMFERENTIAL MARGIN** *[DISTANCE TO CLOSEST NON PERITONEALISED RESECTION MARGIN]*	max n2.max n2	R
CO5230	COLORECTAL - PATHOLOGY	**DISTANCE BETWEEN LOWER END OF TUMOUR AND DISTAL RESECTION MARGIN** *[DISTANCE TO DISTAL RESECTION MARGIN]*	max n4.max n2	R
CO5250	COLORECTAL - PATHOLOGY	**PERFORATIONS OR SEROSAL INVOLVEMENT INDICATION CODE**	an1	R
CO5260	COLORECTAL - PATHOLOGY	**PLANE OF SURGICAL EXCISION** *[PLANE OF SURGICAL EXCISION TYPE]*	an1	R
CO5270	COLORECTAL - PATHOLOGY	**DISTANCE FROM DENTATE LINE**	max n3.max n2	R
CO5280	COLORECTAL - PATHOLOGY	**DISTANCE BEYOND MUSCULARIS PROPRIA**	max n3.max n2	R
CO5290	COLORECTAL - PATHOLOGY	**RESPONSE TO PREOPERATIVE THERAPY** *[PREOPERATIVE THERAPY RESPONSE TYPE]*	an1	R
CO5300	COLORECTAL - PATHOLOGY	**STATUS OF CIRCUMFERENTIAL EXCISION MARGIN** *[MARGIN INVOLVED INDICATION CODE (CIRCUMFERENTIAL MARGIN)]*	an1	R
CO5310	COLORECTAL - PATHOLOGY	**DISTANCE TO CIRCUMFERENTIAL EXCISION MARGIN***	max n3.max n2	R

INVESTIGATION RESULT DATE: The date on which an investigation was concluded e.g. the date the result was authorised.

SERVICE REPORT IDENTIFIER: A unique identifier of a SERVICE REPORT.

POSITIVE PROXIMAL OR DISTAL RESECTION MARGIN: Record whether the proximal or distal resection margins were involved. If the minimal distance from the cut margin is less than or equal to 1 mm the margin is considered "involved".

0	Margin not involved
1	Margin involved
9	Not known

DISTANCE TO CIRCUMFERENTIAL MARGIN: Record the distance from the outer margin of the tumour to the closest non peritonealised circumferential resection margin in mm. RECTAL CANCERS ONLY.

Note: For COSD reporting purposes, this data item is only required to be submitted to one decimal place.

DISTANCE BETWEEN LOWER END OF TUMOUR AND DISTAL RESECTION MARGIN: Record the distance between the lower end of the tumour and the distal resection margin in mm. ALL COLORECTAL CANCERS.

Note: For COSD reporting purposes, this data item is only required to be submitted to one decimal place.

PERFORATIONS OR SEROSAL INVOLVEMENT INDICATION CODE: Is there continuity between the lumen of the bowel and the serosal surface or surgical resection margin through the tumour.

T	Yes, tumour perforation only
B	Yes, bowel perforation but not through tumour
Y	Yes, both bowel and tumour perforation
N	No perforation

PLANE OF SURGICAL EXCISION: FOR RECTAL CANCERS ONLY. This is the quality of the surgical excision as seen by the pathologist. This grades the resection on its worst plane.

1	Mesorectal fascia
2	Intramesorectal
3	Muscularis propria

DISTANCE FROM DENTATE LINE: For abdominoperineal excision specimens only. Record the distance of the tumour from the dentate line in mm measured on the gross specimen.
Note: For COSD reporting purposes, this data item is only required to be submitted to one decimal place.
DISTANCE BEYOND MUSCULARIS PROPRIA: Maximum distance of spread beyond muscularis propria in mm. If there is doubt about the sites of the muscularis propria estimate the distance as accurately as possible.
Note: For COSD reporting purposes, this data item is only required to be submitted to one decimal place.
RESPONSE TO PREOPERATIVE THERAPY: If preoperative therapy was given what was the response.

1	No residual tumour cells/mucous lakes only
2	Minimal residual cancer
3	No marked regression

STATUS OF CIRCUMFERENTIAL EXCISION MARGIN: Record if the edge of the tumour is 1 mm or less from the circumferential resection margin (i.e. margin involved) Circumferential margin refers to the completeness of the surgeon's resection margin in the opinion of the histopathologist. In parts of the colon where it is completely surrounded by peritoneum, recording of the circumferential resection margin (CRM) is not appropriate.

0	Margin not involved
1	Margin involved
9	Not known

DISTANCE TO CIRCUMFERENTIAL EXCISION MARGIN: ****This data item is currently suspended as it duplicates data item DISTANCE TO CIRCUMFERENTIAL MARGIN (CO5210). It is expected that it will be removed from the COSD upon its next formal review.***
Record the distance from the tumour to the circumferential margin in mm.
Note: For COSD reporting purposes, this data item is only required to be submitted to one decimal place.

5. CHILDREN TEENAGERS AND YOUNG ADULTS

5.1 OVERVIEW

There is no nationally agreed standardised categorisation by age and the following groupings are used for COSD:

- Paediatric = under 16 years at time of diagnosis
- Teenage = 16 – 18 years (under 19) at time of diagnosis
- Young Adult = 19 – 24 at time of diagnosis

For all patients under 25 more than one dataset may be required depending on the nature of the disease and the management of the patient. The following guidelines are intended to support the decision on which datasets should be submitted.

Where the patient is discussed by an age specific (paediatric or TYA) MDT at a designated paediatric or TYA Principal Treatment Centre (PTC), the responsibility for completing the CTYA dataset rests with the PTC. For patients (of any age) who are also discussed at a site specific MDT, or where the disease is not specified in the CTYA dataset, (for example the diagnosis of a colorectal carcinoma), the appropriate site specific dataset should also be completed by the relevant MDT.

National guidance offers TYA aged 19-24 years the option of referral to a TYA PTC, although the guidance also indicates that all such patients should be discussed at a TYA MDT even if they are not referred to the PTC for treatment. If, despite this, the patient is only discussed by a site specific MDT, that team should complete the appropriate site specific dataset *and* the relevant additional (non disease specific) items in the CTYA dataset.

Where a disease is covered by both the CTYA and a site specific dataset (such as some haematological diseases), only one set of disease specific items needs to be completed (either CTYA or site specific according to the speciality of the treating team). The non disease specific items in the CTYA dataset should however be completed as per the preceding paragraphs.

Please note that CANCER SYMPTOMS FIRST NOTED DATE, which records when symptoms were first noted, is included in the Referral section of the Core dataset and should be completed for all under 25s.

5.2 ICD-10 CODES

Any applicable ICD10 code where the patient is under 25 at the time of diagnosis (see Appendices A and B).

5.3 CTYA – TABLES OF DATA ITEMS TO BE COMPLETED

5.3.1 Data items applicable to all cases (any diagnosis)

√ = to be completed for all cases (√) = to be completed for all cases where applicable

Data item No.	Data Item Name	All cases
CT6050	SPECIALTY (REFERRER TO SPECIALIST)	√
CT6060	PRIMARY DIAGNOSIS SUBSIDIARY COMMENT	(√)
CT6070	SECONDARY DIAGNOSIS (ICD)	(√)
CT6080	OTHER SIGNIFICANT DIAGNOSIS SUBSIDIARY COMMENT	(√)
CT6090	FAMILIAL CANCER SYNDROME	(√)

CT6100	FAMILIAL CANCER SYNDROME SUBSIDIARY COMMENT	(√)
CT6030	CONSULTANT SPECIALTY (AT DIAGNOSIS)	√
CT6040	CONSULTANT AGE SPECIALTY (AT DIAGNOSIS)	√
CT6110	MULTIDISCIPLINARY TEAM AGE CATEGORY	√
CT6150	STEM CELL INFUSION DATE	(√)
CT6130	STEM CELL INFUSION SOURCE	(√)
CT6140	STEM CELL INFUSION DONOR	(√)
CT6160	SPECIALTY SUB CODE (CHEMOTHERAPY CONSULTANT)	√

5.3.2 Disease specific Data items

The following table shows which data items are applicable to each specific diagnosis.

√ = to be completed for all disease specific cases

(√) = to be completed for all disease specific cases if applicable

Data item No.	Data Item Name	ALL (Acute Lymphocytic Leukaemia)	AML	NHL	Hodgkin's Lymphoma	Neuroblastoma	Renal	Rhabdomyosarcoma and other Soft Tissue Sarcomas	STS excluding Rhabdomyosarcoma	Osteosarcoma	Ewings	Germ Cell CNS	Germ Cell Non CNS	Medulloblastoma	Hepatoblastoma
CT6210	EXTRAMEDULLARY DISEASE	√	√												
CT6220	WHITE BLOOD CELL COUNT (HIGHEST PRE TREATMENT)	√	√												
CT6230	CYTOGENETIC RISK CODE	√	√												
CT6240	CYTOGENETICS SUBSIDIARY COMMENT	√	√												
CT6250	MURPHY (ST JUDE) STAGE			√											
CT6260	ALK-1 STATUS FOR ALCL			√											
CT6270	ANN ARBOR STAGE				√										
CT6280	ANN ARBOR SYMPTOMS				√										
CT6290	ANN ARBOR EXTRANODALITY				√										

CT6300	INTERNATIONAL NEUROBLASTOMA PATHOLOGIC CLASSIFICATION					√									
CT6310	CYTOGENETIC RISK CLASSIFICATION (NEUROBLASTOMA)					√									
CT6320	INTERNATIONAL NEUROBLASTOMA STAGING SYSTEM					√									
CT6330	WILMS TUMOUR STAGE						√								
CT6680	RISK CLASSIFICATION (PATHOLOGICAL) AFTER IMMEDIATE NEPHRECTOMY						√								
CT6340	RISK CLASSIFICATION (PATHOLOGICAL)AFTER PREOPERATIVE CHEMOTHERAPY						√								
CT6350	IRS POST SURGICAL GROUP							√							
CT6360	CYTOGENETICS FOR ALVEOLAR RHABDOMYOSARCOMA							√							
CT6370	RHABDOMYOSARCOMA SITE PROGNOSIS CODE							√							
CT6380	SARCOMA TUMOUR SITE (SOFT TISSUE OTHER THAN RHABDOMYOSARCOMA)								√						

Data item No.	Data Item Name	ALL (Acute Lymphocytic Leukaemia)	AML	NHL	Hodgkin's Lymphoma	Neuroblastoma	Renal	Rhabdomyosarcoma and other Soft Tissue Sarcomas	STS excluding Rhabdomyosarcoma	Osteosarcoma	Ewings	Germ Cell CNS	Germ Cell Non CNS	Medulloblastoma	Hepatoblastoma
CT6390	SARCOMA TUMOUR SUBSITE (SOFT TISSUE) OTHER THAN RHABDOMYOSARCOMA								√						
CT6400	PRIMARY TUMOUR SIZE (RADIOLOGICAL)									√					
CT6410	EXTENT OF NECROSIS AFTER CHEMOTHERAPY									√					
CT6420	SARCOMA SURGICAL MARGIN ADEQUACY									√					
CT6450	TUMOUR VOLUME AT DIAGNOSIS										√				
CT6460	CYTOGENETICS FOR EWINGS SARCOMA										√				
CT6470	SARCOMA TUMOUR SITE (BONE)									√	√				
CT6440	SARCOMA TUMOUR SUBSITE (BONE)									√	√				
CT6530	ALPHA FETOPROTEIN (CEREBROSPINAL FLUID)											√			
CT6550	BETA HUMAN CHORIONIC GONADOTROPIN (CEREBROSPINAL FLUID)											√			
CT6590	TNM STAGE GROUPING FOR NON CNS GERM CELL TUMOURS												√		
CT6580	BETA HUMAN CHORIONIC GONADOTROPIN (SERUM)											√	√		
CT6520	ALPHA FETOPROTEIN (SERUM)											√	√		√
CT6560	CHANG STAGING FOR MEDULLOBLASTOMA													√	
CT6500	PRETEXT STAGING SYSTEM STAGE														√
CT6510	PRETEXT STAGING OUTSIDE LIVER														√
CT6690	INVESTIGATION RESULT DATE						√								
CT6610	TUMOUR RUPTURE						√								
CT6620	ANAPLASTIC NEPHROBLASTOMA						√								
CT6630	PERIRENAL FAT INVASION						√								
CT6640	RENAL SINUS INVASION						√								
CT6650	RENAL VEIN TUMOUR						√								
CT6660	VIABLE TUMOUR						√								
CT6670	TUMOUR LOCAL STAGE (PATHOLOGICAL)						√								

Note: This data item is also in the core for all pathology. This is an additional use of this data item to enable the Renal dataset to be identified.

5.4 CTYA – REFERRALS (All cases)

To carry referrals details for CTYA.

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CT6050	CTYA - MAIN - REFERRALS	**SPECIALTY (REFERRER TO SPECIALIST)** *[CARE PROFESSIONAL MAIN SPECIALTY CODE (CANCER REFERRAL)]*	an3	M

SPECIALTY (REFERRER TO SPECIALIST): The specialty of the person referring to the patients Principal Treatment Centre or age specific Specialist TYA MDT.

Main Specialty and Treatment Function Codes

5.5 CTYA – DIAGNOSIS (All cases)

To carry diagnosis details for CTYA.

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CT6060	CTYA - DIAGNOSIS	**PRIMARY DIAGNOSIS SUBSIDIARY COMMENT** *[PRIMARY DIAGNOSIS (CANCER COMMENT)]*	max an50	R
Start of repeating item - Secondary Diagnosis (ICD)				
CT6070	CTYA - DIAGNOSIS	**SECONDARY DIAGNOSIS (ICD)**	an6	R
End of repeating item - Secondary Diagnosis (ICD)				
CT6080	CTYA - DIAGNOSIS	**OTHER SIGNIFICANT DIAGNOSIS SUBSIDIARY COMMENT** *[SECONDARY DIAGNOSIS (CANCER COMMENT)]*	max an50	R
CT6090	CTYA - DIAGNOSIS	**FAMILIAL CANCER SYNDROME** *[FAMILIAL CANCER SYNDROME INDICATOR]*	an1	M
CT6100	CTYA - DIAGNOSIS	**FAMILIAL CANCER SYNDROME SUBSIDIARY COMMENT** *[FAMILIAL CANCER SYNDROME COMMENT]*	max an50	R
CT6030	CTYA - DIAGNOSIS	**CONSULTANT SPECIALTY (AT DIAGNOSIS)** *[CARE PROFESSIONAL MAIN SPECIALTY CODE (DIAGNOSIS)]*	an3	R
CT6040	CTYA - DIAGNOSIS	**CONSULTANT AGE SPECIALTY (AT DIAGNOSIS)** *[CHILDREN TEENAGERS AND YOUNG ADULTS AGE CATEGORY (CONSULTANT AT DIAGNOSIS)]*	an1	R

PRIMARY DIAGNOSIS SUBSIDIARY COMMENT: (Optional)

Additional comments on diagnosis where coding is difficult or imprecise.

(Examples of this would be: "papillary glioneuronal tumour" or "angiocentric glioma" to specify recently described diagnoses which do not have ICD10 or ICD-O-3 coding. "Anaplastic ependymoma" or "ependymoblastoma" to distinguish between these two diagnoses which may have different treatment decisions or outcomes but which cannot be distinguished in ICD10 or ICD-O-3 coding.)"

SECONDARY DIAGNOSIS (ICD): Optional. Types (ICD10 codes) of other significant conditions (e.g. Down Syndrome, NF1, Fanconi anaemia) which may predispose to cancer or influence treatment. Possible multiple entries. This information should be available for the MDT discussion but will only apply to a small number of cases. See Appendix D for list of Associated Conditions to be Recorded on Childhood Cancer Registration Forms.

OTHER SIGNIFICANT DIAGNOSIS SUBSIDIARY COMMENT: (Optional) Additional comments on other significant conditions where coding is difficult or imprecise. (For example “NF1” or “NF2” to distinguish between these two distinct conditions which may have different treatment decisions or outcomes but cannot be coded separately.) This information should be available for the MDT discussion but will only apply to a small number of cases.

FAMILIAL CANCER SYNDROME: Indicate whether there is a possible or confirmed familial cancer syndrome. This information should be available for the MDT discussion but will only apply to a small number of cases. The following definitions are used:

Y	Yes
N	No
P	Possible
9	Not Known

FAMILIAL CANCER SYNDROME SUBSIDIARY COMMENT: (Optional)

Where Familial Cancer Syndrome is coded as “Yes” or “Possible”, this field can be used to provide further details. For example “Li-Fraumeni”, “Rhabdoid tumour predisposition syndrome” or “Biallelic PMS2 mutation” to identify distinct syndromes which may have different treatment decisions or outcomes but cannot be coded separately.

CONSULTANT SPECIALTY (AT DIAGNOSIS): The specialty of the consultant responsible for the patient at the time of diagnosis.

Main Specialty and Treatment Function Codes

CONSULTANT AGE SPECIALTY (AT DIAGNOSIS): The age group specialty of the consultant responsible for the patient at the time of diagnosis. This will be defined by the MDT.

P	Paediatric
T	Teenage and Young Adult
A	Adult

5.6 CTYA - CANCER CARE PLAN

To carry cancer care plan details for CTYA.

One occurrence of this data group is permitted.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
Start of repeating item – Multidisciplinary Team Age Category				
CT6110	CTYA - CANCER CARE PLAN	**MULTIDISCIPLINARY TEAM AGE CATEGORY** *[CHILDREN TEENAGERS AND YOUNG ADULTS AGE CATEGORY (MULTIDISCIPLINARY TEAM)]*	an1	R
Start of repeating item – Multidisciplinary Team Age Category				

MULTIDISCIPLINARY TEAM AGE CATEGORY: Type(s) of MDT where the care plan for the patient was discussed. More than one option can be recorded. This field defines the nature of each MDT at which the patient's care plan is discussed.

P	Paediatric
T	Teenage and Young Adult
A	Adult

5.7 CTYA - STEM CELL TRANSPLANTATION

To carry stem cell transplantation details for CTYA.

This section can be recorded more than once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CT6150	CTYA - MAIN - STEM CELL TRANSPLANTATION	**STEM CELL INFUSION DATE** *[PROCEDURE DATE (STEM CELL INFUSION)]*	an10 ccyy-mm-dd	M
CT6130	CTYA - MAIN - STEM CELL TRANSPLANTATION	**STEM CELL INFUSION SOURCE** *[STEM CELL INFUSION SOURCE CODE]*	an1	R
CT6140	CTYA - MAIN - STEM CELL TRANSPLANTATION	**STEM CELL INFUSION DONOR** *[STEM CELL INFUSION DONOR TYPE]*	an1	R

STEM CELL INFUSION DATE: Date of stem cell infusion

STEM CELL INFUSION SOURCE: Source of stem cells for infusion

B	Bone Marrow
P	Peripheral Blood
C	Cord
9	Not known

STEM CELL INFUSION DONOR: Donor for stem cell infusion.

1	Autologous
2	Allogeneic - Sibling

3	Allogeneic - Haplo
4	Allogeneic - Unrelated
9	Not Known

5.8 CTYA – CHEMOTHERAPY

To carry chemotherapy details for CTYA.

This section will be recorded once per treatment where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CT6160	CTYA - MAIN - CHEMOTHERAPY	**SPECIALTY SUB CODE (CHEMOTHERAPY CONSULTANT)** *[CHILDREN TEENAGERS AND YOUNG ADULTS AGE CATEGORY (CONSULTANT PRESCRIBING CHEMOTHERAPY)]*	an1	M

SPECIALTY SUB CODE (CHEMOTHERAPY CONSULTANT): The age group specialty of the consultant responsible for prescription of chemotherapy.

P	Paediatric
T	Teenage and Young Adult
A	Adult Only

5.9 CTYA – ACUTE LEUKAEMIA LYMPHOCYTIC and MYELOID

To carry Acute Leukaemia Lymphocytic and Myeloid details for CTYA.

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CT6210	CTYA (Acute Lymphocytic Leukaemia & AML)	**EXTRAMEDULLARY DISEASE** *[EXTRAMEDULLARY DISEASE SITE]*	an1	R
CT6220	CTYA (Acute Lymphocytic Leukaemia & AML)	**WHITE BLOOD CELL COUNT (HIGHEST PRETREATMENT)**	max n3.n1	R
CT6230	CTYA (Acute Lymphocytic Leukaemia & AML)	**CYTOGENETIC RISK CODE** *CYTOGENETIC RISK CODE (ACUTE LYMPHOCYTIC LEUKAEMIA AND ACUTE MYELOID LEUKAEMIA)*	an1	R
CT6240	CTYA (Acute Lymphocytic Leukaemia & AML)	**CYTOGENETICS SUBSIDIARY COMMENT** *[CYTOGENETIC FINDINGS COMMENT]*	max an50	R

EXTRAMEDULLARY DISEASE: Sites of disease identified outside bone marrow.

T	Testes
C	CNS
O	Other

WHITE BLOOD CELL COUNT (HIGHEST PRETREATMENT): Highest white blood cell count pre-treatment (x 10 to the power of 9 g per litre).

(range 0.0 to 999.9)

CYTOGENETIC RISK CODE: Risk allocation based on cytogenetic findings. This should be available for the MDT discussion but will only apply to a small number of cases.

F	Favourable
A	Adverse
I	Intermediate
N	No result
O	Other

CYTOGENETICS SUBSIDIARY COMMENT: (Optional)

Description of cytogenetic findings. This field would not normally be completed. It should only be completed where the current coding is unable to distinguish between diagnoses for which treatments and outcomes may vary. (For example "Philadelphia positive ALL". This is a subtype of ALL which cannot be coded separately but which has its own clinical trial and treatment protocol.)

5.10 CTYA – NON HODGKIN LYMPHOMA

To carry CTYA Non Hodgkin Lymphoma details for CTYA.

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CT6250	CTYA - NON HODGKIN LYMPHOMA	**MURPHY (ST JUDE) STAGE** *[MURPHY ST JUDES STAGE]*	an1	R
CT6260	CTYA - NON HODGKIN LYMPHOMA	**ALK-1 STATUS FOR ALCL** *[ALK-1 STATUS]*	an1	R

MURPHY (ST JUDE) STAGE: The St. Jude Children's Research Hospital model (Murphy Staging), which separates patients on the basis of limited versus extensive disease. (http://www.cancer.gov/cancertopics/pdq/treatment/child-non-hodgkins/HealthProfessional/page3).

It is essential to record the disease specific stage for this group of patients. This information should be available to the MDT. The following definitions are used:

- Stage 1 - disease is limited to a single tumour or to one lymph node group (e.g., neck, axilla, groin, etc.) outside of the abdomen or mediastinum.
- Stage 2 - disease is limited to one tumour with local lymph node involvement; or to two or more tumours or lymph node groups on the same side of the diaphragm; or to a completely resected primary tumour of the gastrointestinal tract with/without involvement of local lymph nodes.

- Stage 3 - disease includes tumours or lymph node groups involved on both sides of the diaphragm; or any primary intrathoracic tumour (mediastinal, pleural or thymic disease); or extensive NHL within the abdomen; or any paraspinal or epidural tumours.
- Stage 4 - disease involves the bone marrow and / or central nervous system (CNS), with/without other sites of involvement. Bone marrow involvement in NHL is defined as >5% - <25% malignant cells in an otherwise normal bone marrow. (> 25% malignant cells in the bone marrow is defined as leukaemia).

1	Stage 1
2	Stage 2
3	Stage 3
4	Stage 4

ALK-1 STATUS FOR ALCL: Activin Receptor-like Kinase 1 (ALK-1) is a gene expression protein which distinguishes prognostically important subsets of this diagnosis.

This should be available for the MDT discussion but will only apply to a small number of cases.

P	ALK - positive
N	ALK - negative
9	Not known

5.11 CTYA – HODGKIN LYMPHOMA

To carry Hodgkin Lymphoma details for CTYA.

This section will be recorded once.

Note: This includes Nodular Lymphocyte Predominant Hodgkin Lymphoma (ICDO3 code 9659/3) for which the staging is the same.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CT6270	CTYA - (HODGKIN LYMPHOMA)	**ANN ARBOR STAGE**	an1	M
CT6280	CTYA - (HODGKIN LYMPHOMA)	**ANN ARBOR SYMPTOMS** *[ANN ARBOR SYMPTOMS INDICATOR]*	an1	R
CT6290	CTYA - (HODGKIN LYMPHOMA)	**ANN ARBOR EXTRANODALITY** [ANN *ARBOR EXTRANODALITY INDICATOR]*	an1	R

ANN ARBOR STAGE: Staging based on location and extent of detected disease. It is essential to record the stage for this group of patients. This information should be available to the MDT.

1	I = One region of lymph nodes, or spleen or thymus or Waldeyer's ring enlarged
2	II = 2 regions of lymph nodes enlarged, on same side of diaphragm
3	III = lymph nodes enlarged on both sides of diaphragm
4	IV = disease outside lymph nodes e.g. liver, bone marrow excluding E

ANN ARBOR SYMPTOMS: Additional stage designation based on presence or absence of specific symptoms.

A	No Symptoms
B	Presence of any of the following: unexplained persistent or recurrent fever (greater than 38°C / 101.5°F), drenching night sweats, unexplained weight loss of 10% or more within the last 6 months

ANN ARBOR EXTRANODALITY: Additional staging designation based on extranodal involvement.

Code "E" if there is involvement of a single extranodal site that directly adjoins or is next to the known nodal group.

E	E (Extranodal involvement)

5.12 CTYA – NEUROBLASTOMA

To carry Neuroblastoma details for CTYA.

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CT6300	CTYA (NEUROBLASTOMA)	**INTERNATIONAL NEUROBLASTOMA PATHOLOGIC CLASSIFICATION** *[INTERNATIONAL NEUROBLASTOMA PATHOLOGY CLASSIFICATION CODE]*	an1	R
CT6310	CTYA (NEUROBLASTOMA)	**CYTOGENETIC RISK CLASSIFICATION (NEUROBLASTOMA)** *[CYTOGENETIC RISK CODE (NEUROBLASTOMA)]*	an1	R
CT6320	CTYA (NEUROBLASTOMA)	**INTERNATIONAL NEUROBLASTOMA STAGING SYSTEM** *[INTERNATIONAL NEUROBLASTOMA STAGING SYSTEM STAGE]*	max an2	R

INTERNATIONAL NEUROBLASTOMA PATHOLOGIC CLASSIFICATION: The International Neuroblastoma Pathologic Classification (INPC) system involves evaluation of tumour specimens obtained prior to therapy for the amount of stromal development, the degree of neuroblastic maturation, and the mitosis-karyorrhexis index of the neuroblastic cells. Favourable and unfavourable prognoses are defined on the base of these histologic parameters.

Note: This should be available for the MDT discussion but will only apply to a small number of cases.

F	Favourable
U	Unfavourable

CYTOGENETIC RISK CLASSIFICATION (NEUROBLASTOMA): Risk allocation based on cytogentic findings

F	Favourable
U	Unfavourable
O	Other
X	Non informative
9	Not known

INTERNATIONAL NEUROBLASTOMA STAGING SYSTEM: International Neuroblastoma Staging System.

Children's Oncology Group Neuroblastoma Risk Grouping.
http://www.cancer.gov/cancertopics/pdq/treatment/neuroblastoma/HealthProfessional/page3

- STAGE 1: Localised tumour with complete gross excision, with or without microscopic residual disease; representative ipsilateral lymph nodes negative for tumour microscopically (nodes attached to and removed with the primary tumour may be positive).

- STAGE 2A: Localised tumour with incomplete gross excision; representative ipsilateral nonadherent lymph nodes negative for tumour microscopically.
- STAGE 2B: Localised tumour with or without complete gross excision, with ipsilateral nonadherent lymph nodes positive for tumour. Enlarged contralateral lymph nodes must be negative microscopically.
- STAGE 3: Unresectable unilateral tumour infiltrating across the midline, with or without regional lymph node involvement; or localised unilateral tumour with contralateral regional lymph node involvement; or midline tumour with bilateral extension by infiltration (unresectable) or by lymph node involvement. The midline is defined as the vertebral column. Tumours originating on 1 side and crossing the midline must infiltrate to or beyond the opposite side of the vertebral column.
- STAGE 4: Any primary tumour with dissemination to distant lymph nodes, bone, bone marrow, liver, skin, and/or other Organs (except as defined for Stage 4S).
- STAGE 4S: Localised primary tumour (as defined for stage 1, 2A, or 2B), with dissemination limited to skin, liver, and/or bone marrow (limited to infants younger than 1 year). Marrow involvement should be minimal (<10% of total nucleated cells identified as malignant by bone biopsy or by bone marrow aspirate). More extensive bone marrow involvement would be considered to be stage 4 disease. The results of the MIBG scan (if performed) should be negative for disease in the bone marrow."

1	Stage 1
2A	Stage 2A
2B	Stage 2B
3	Stage 3
4	Stage 4
4S	Stage 4S

5.13 CTYA - RENAL TUMOURS

To carry renal tumours details for CTYA.

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CT6330	CTYA (RENAL TUMOURS)	**WILMS TUMOUR STAGE**	an1	R
CT6680	CTYA (RENAL TUMOURS)	**RISK CLASSIFICATION (PATHOLOGICAL) AFTER IMMEDIATE NEPHRECTOMY** *[PATHOLOGICAL RISK CLASSIFICATION CODE (AFTER NEPHRECTOMY)]*	an1	R
CT6340	CTYA (RENAL TUMOURS)	**RISK CLASSIFICATION (PATHOLOGICAL) AFTER PREOPERATIVE CHEMOTHERAPY** *[PATHOLOGICAL RISK CLASSIFICATION CODE (AFTER PREOPERATIVE CHEMOTHERAPY)]*	an1	R

WILMS TUMOUR STAGE: Stage is determined by the results of the imaging studies and both the surgical and pathologic findings at nephrectomy. It is essential to record the stage for this group of patients and this information should be available to the MDT following treatment.

- Stage 1 - tumour is limited to the kidney and completely resected.
- Stage 2 - tumour is completely resected, and there is no evidence of tumour at or beyond the margins of resection but the tumour extends beyond the kidney (penetration of capsule, invasion of blood vessels outside renal parenchyma).
- Stage 3 - there is residual tumour following surgery that is confined to the abdomen.

- Stage 4 - there are distant metastases (lung, liver, bone, brain), or lymph node metastases outside the abdominopelvic region.
- Stage 5 - involvement of both kidneys is present at diagnosis.

1	Stage 1
2	Stage 2
3	Stage 3
4	Stage 4
5	Stage 5

RISK CLASSIFICATION (PATHOLOGICAL) AFTER IMMEDIATE NEPHRECTOMY: Classification and timing of surgery determine histological risk. This information should be available for the MDT discussion following treatment but will only apply to a small number of cases. The following definitions are used:

- Favourable histology: non-anaplastic Wilms tumour (all subtypes); cystic partially differentiated nephroblastoma; mesoblastic nephroma; diffuse nephroblastomatosis.
- Unfavourable histology: Anaplastic Wilms tumour (focal and diffuse); malignant rhabdoid tumour of kidney; clear cell sarcoma of the kidney; renal cell carcinoma.

F	FAVOURABLE
U	UNFAVOURABLE

RISK CLASSIFICATION (PATHOLOGICAL) AFTER PREOPERATIVE CHEMOTHERAPY: Classification after preoperative chemotherapy determines histological risk. This information should be available for the MDT discussion following treatment but will only apply to a small number of cases. The following definitions are used:

• Low risk: cystic partially differentiated nephroblastoma; completely necrotic nephroblastoma; mesoblastic nephroma; diffuse nephroblastomatosis

• Intermediate risk: nephroblastoma type – epithelial; stromal; mixed; regressive; focal anaplasia

• High risk: nephroblastoma blastemal type; nephroblastoma with anaplasia; malignant rhabdoid tumour of the kidney; clear cell sarcoma of the kidney; renal cell carcinoma

L	Low
I	Intermediate
H	High

5.14 CTYA - RHABDOMYOSARCOMA and OTHER SOFT TISSUE SARCOMAS

To carry Rhabdomyosarcoma and other Soft Tissue Sarcoma details for CTYA.

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CT6350	CTYA (RHABDOMYOSARCOMA and OTHER STS)	**IRS POST SURGICAL GROUP** *[INTERGROUP RHABDOMYOSARCOMA STUDY POST-SURGICAL GROUPING SYSTEM STAGE]*	an1	R
CT6360	CTYA (RHABDOMYOSARCOMA and OTHER STS)	**CYTOGENETICS FOR ALVEOLAR RHABDOMYOSARCOMA** *[CYTOGENETIC PRESENCE TYPE (RHABDOMYOSARCOMA)]*	an1	R

CT6370	CTYA (RHABDOMYOSARCOMA and OTHER STS)	**RHABDOMYOSARCOMA SITE PROGNOSIS CODE**	an1	R
CT6380	CTYA (RHABDOMYOSARCOMA and OTHER STS)	**SARCOMA TUMOUR SITE (SOFT TISSUE OTHER THAN RHABDOMYOSARCOMA)** *[SARCOMA TUMOUR SITE (SOFT TISSUE)]*	an4	R
CT6390	CTYA (RHABDOMYOSARCOMA and OTHER STS)	**SARCOMA TUMOUR SUBSITE (SOFT TISSUE) OTHER THAN RHABDOMYOSARCOMA** *[SARCOMA TUMOUR SUBSITE (SOFT TISSUE]*	an2	R

IRS POST SURGICAL GROUP: IRS group defines the post-surgical disease status at diagnosis. This information should be available for the MDT discussion following treatment but will only apply to a small number of cases. The following definitions are used:

- Group 1 = primary complete resection
- Group 2 = microscopic residual disease or primary complete resection with (completely resected) lymph node involvement
- Group 3 = macroscopic residual disease
- Group 4 = distant metastases

1	Group 1
2	Group 2
3	Group 3
4	Group 4

CYTOGENETICS FOR ALVEOLAR RHABDOMYOSARCOMA: Presence of a specific cytogenetic abnormality. This information should be available for the MDT discussion but will only apply to a small number of cases. The following definitions are used:

P	Fusion positive
N	Fusion negative
X	Non informative
9	Not known (Not available)

RHABDOMYOSARCOMA SITE PROGNOSIS CODE: Grouping of anatomical sites which imply prognostic significance. This information should be available for the MDT discussion but will only apply to a small number of cases. The following definitions are used:

Favourable sites: Orbit; genitourinary Non Bladder Prostate; Non-Parameningeal Head and Neck

Unfavourable sites: All other sites of disease

F	Favourable
U	Unfavourable

SARCOMA TUMOUR SITE (SOFT TISSUE OTHER THAN RHABDOMYOSARCOMA): Location of the soft tissue sarcoma within the body (more specific than ICD10/ICDO3 sites)

Z272	Stomach
Z301	Liver
Z459	Uterus
Z533	Peritoneum
Z891	Shoulder

Z892	Upper Arm
Z893	Forearm
Z894	Hand
Z898	Specified Arm Region (to include wrist and elbow)
Z901	Buttock
Z903	Upper Leg (to include thigh)
Z904	Lower Leg (to include calf)
Z905	Foot
Z908	Specified leg region (to include groin, knee, ankle)
Z921	Head
Z923	Neck
Z924	Chest (to include Intrathoracic)
Z927	Trunk (to include upper and lower)
Z928	Multiple
Z929	Unknown

SARCOMA TUMOUR SUBSITE (SOFT TISSUE) OTHER THAN RHABDOMYOSARCOMA: Sublocation of the soft tissue sarcoma within the tumour site. This is additional detail to enable a more precise localisation of the tumour site.

RP	Retroperitoneal (subsite of Z53.3)
IP	Intraperitoneal (subsite of Z53.3)
WR	Wrist (subsite of Z89.8)
EB	Elbow (subsite of Z89.8)
UT	Upper Trunk (subsite of Z92.7)
LT	Lower Trunk (subsite of Z92.7)
AD	Adductors (subsite of Z90.3 & Z90.4)
AN	Anterior (subsite of Z90.3 & Z90.4)
PO	Posterior (subsite of Z90.3 & Z90.4)
LA	Lateral (subsite of Z90.3 & Z90.4)
NK	Not Known
NA	Not Applicable

5.15 CTYA – OSTEOSARCOMA

To carry Osteosarcoma details for CTYA.

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CT6400	CTYA OSTEOSARCOMA	**PRIMARY TUMOUR SIZE (Radiological)**	max n3.max n2	R
CT6410	CTYA OSTEOSARCOMA	**EXTENT OF NECROSIS AFTER CHEMOTHERAPY** *[TUMOUR NECROSIS]*	max n3	R
CT6420	CTYA OSTEOSARCOMA	**SARCOMA SURGICAL MARGIN ADEQUACY** *[SARCOMA SURGICAL MARGIN]*	an1	R

PRIMARY TUMOUR SIZE (Radiological): Maximum dimension in mm recorded on diagnostic imaging as agreed at MDT. This information should be available for the MDT discussion but will only apply to a small number of cases.

Note: For COSD reporting purposes, this data item is not required to be submitted to two decimal places.

EXTENT OF NECROSIS AFTER CHEMOTHERAPY: Pathologically assessed effect of chemotherapy on the resected tumour specimen as a percentage. This information should be available for the MDT discussion following treatment but will only apply to a small number of cases.

SARCOMA SURGICAL MARGIN ADEQUACY: Pathological assessment of completeness of resection. This information should be available for the MDT discussion following treatment but will only apply to a small number of cases.

I	Intralesional
M	Marginal
W	Wide
C	Compartmental
O	Other
9	Not known

5.16 CTYA – EWINGS

To carry Ewings details for CTYA.

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CT6450	CTYA (EWINGS)	**TUMOUR VOLUME AT DIAGNOSIS** *[TUMOUR VOLUME AT DIAGNOSIS CODE]*	an1	R
CT6460	CTYA (EWINGS)	**CYTOGENETICS FOR EWINGS SARCOMA** *[CYTOGENETIC ANALYSIS CODE]*	an2	R

TUMOUR VOLUME AT DIAGNOSIS: Radiologically calculated estimate of tumour volume at diagnosis which has value in determining treatment. This information should be available for the MDT discussion but will only apply to a small number of cases. The following definitions are used:

L	Less than 200ml
M	200ml or greater

CYTOGENETICS FOR EWINGS SARCOMA: Cytogenetic analysis. This information should be available for the MDT discussion but will only apply to a small number of cases. The following definitions are used:

11	t(11;22)
VT	Variant Translocation
NG	Negative
NA	Not Available

5.17 CTYA – OSTEOSARCOMA and EWINGS

To carry Osteosarcoma and Ewings details for CTYA.

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CT6470	CTYA (OSTEOSARCOMA and EWINGS)	**SARCOMA TUMOUR SITE (BONE)**	an4	M
CT6440	CTYA (OSTEOSARCOMA and EWINGS)	**SARCOMA TUMOUR SUBSITE (BONE)**	an2	R

SARCOMA TUMOUR SITE (BONE): Location of the bone sarcoma within the body (more specific than ICD10/ICDO3 sites).

Z639	Cranium
Z649	Face
Z659	Jaw
Z663	Cervical Spine
Z664	Thoracic Spine
Z665	Lumbar Spine
Z681	Clavicle
Z684	Glenoid
Z685	Scapula
Z699	Humerus
Z709	Radius
Z719	Ulna
Z724	Carpal
Z732	Metacarpal
Z733	Thumb
Z734	Finger
Z742	Sternum
Z746	Rib
Z751	Sacrum
Z753	Ileum
Z754	Ischium
Z755	Pubis
Z756	Acetabulum
Z757	Coccyx
Z769	Femur
Z779	Tibia
Z786	Fibula
Z787	Patella
Z799	Tarsus
Z802	Metatarsus
Z803	Great toe
Z804	Toe
Z928	Multiple

SARCOMA TUMOUR SUBSITE (BONE): Sublocation of the bone sarcoma within the tumour site.

PR	Proximal
DS	Distal
DP	Diaphyseal (Middle)
TO	Total
OO	Other
NK	Not known

5.18 CTYA - GERM CELL CNS TUMOURS

To carry Germ Cell CNS Tumours details for CTYA. (CNS germ-cell tumours are defined as ICD10 C70.0-C72.9, C75.1-C75.3, D32.0-D33.9, D35.2-D35.4, D42.0-D43.9, D44.3-D44.5 combined with Morphology 9060-9104.)

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CT6530	CTYA (GERM CELL CNS TUMOURS)	**ALPHA FETOPROTEIN (CEREBROSPINAL FLUID)**	max n6	R
CT6550	CTYA (GERM CELL CNS TUMOURS)	**BETA HUMAN CHORIONIC GONADOTROPIN (CEREBROSPINAL FLUID)**	max n3	R

ALPHA FETOPROTEIN (CEREBROSPINAL FLUID): Maximum level of alpha feto protein in the Cerebro Spinal Fluid at diagnosis. AFP units recorded in kU/l (values > 100,000 are recorded. (Measured only for CNS germ cell tumours.)

BETA HUMAN CHORIONIC GONADOTROPIN (CEREBROSPINAL FLUID): Maximum CSF level of HCG at diagnosis in IU/l. (Measured only for CNS germ cell tumours).

5.19 CTYA - GERM CELL NON CNS TUMOURS

To carry Germ Cell Non CNS Tumours details for CTYA. (Non-CNS germ-cell tumours are defined as ICD10 C00.0-C69.9, C73-C75.0, C75.4-C80.9, D00.0-D31.9, D34-D35.1, D35.5-D41.9, D44.0-D44.2, D44.6-D48.9 combined with Morphology 9060-9104.)

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CT6590	CTYA (GERM CELL NON CNS TUMOURS)	**TNM STAGE GROUPING FOR NON CNS GERM CELL TUMOURS** *[TNM STAGE GROUPING (NON CENTRAL NERVOUS SYSTEM GERM CELL TUMOURS)]*	an1	M

TNM STAGE GROUPING FOR NON CNS GERM CELL TUMOURS: TNM classification for Germ Cell Non CNS Tumours. This information should be available for the MDT discussion but will only apply to a small number of cases. Staging is an important prognostic and outcomes analysis factor. The following definitions are used:

1	Clinical stage 1 : T1, N0 or Nx, M0
2	Clinical stage 2 : T2 or T3, N0 or Nx, M0
3	Clinical stage 3 : T1-3, N0, M0 or T4 with any N, M0
4	Clinical stage 4 : All T with any N, M1

5.20 CTYA - GERM CELL CNS AND GERM CELL NON CNS TUMOURS

To carry Germ cell CNS and Germ Cell non CNS Tumours details for CTYA.

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CT6580	CTYA (GERM CELL CNS and GERM CELL NON CNS TUMOURS)	**BETA HUMAN CHORIONIC GONADOTROPIN (SERUM)** *[BETA HUMAN CHORIONIC GONADOTROPIN (MAXIMUM AT DIAGNOSIS)]*	max n3	M

BETA HUMAN CHORIONIC GONADOTROPIN (SERUM): Maximum Serum level of HCG at diagnosis in IU/l (measured only for CNS germ cell tumours.)

5.21 CTYA – GERM CELL CNS, GERM CELL NON CNS, HEPATOBLASTOMA AND HEPATOCELLULAR CARCINOMA

To carry Germ Cell CNS, Germ Cell Non CNS Tumours, Hepatoblastoma and Hepatocellular carcinoma details for CTYA.

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CT6520	CTYA (GERM CELL CNS, GERM CELL NON CNS, HEPATOBLASTOMA and HEPATOCELLULAR CARCINOMA)	**ALPHA FETOPROTEIN (SERUM)** *[ALPHA FETOPROTEIN (MAXIMUM AT DIAGNOSIS)]*	max n6	M

ALPHA FETOPROTEIN (SERUM): Maximum Serum level of alpha feto protein at diagnosis. AFP units recorded in kU/l (values > 100,000 are recorded)

5.22 CTYA – MEDULLOBLASTOMA

To carry Medulloblastoma details for CTYA.

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CT6560	CTYA (MEDULLOBLASTOMA)	**CHANG STAGING FOR MEDULLOBLASTOMA** *[CHANG STAGING SYSTEM STAGE]*	an2	M

CHANG STAGING FOR MEDULLOBLASTOMA: Chang stage for Medulloblastoma.

M0	No evidence of metastatic disease
M1	microscopic tumour cells found in CSF
M2	gross nodular seeding in cerebellum, cerebral subarachnoid space, or in the third or fourth ventricles
M3	gross nodular seeding in spinal subarachnoid space

5.23 CTYA - HEPATOBLASTOMA

To carry Hepatoblastoma details for CTYA.

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CT6500	CTYA (HEPATOBLASTOMA)	**PRETEXT STAGING SYSTEM STAGE**	an1	M
CT6510	CTYA (HEPATOBLASTOMA)	**PRETEXT STAGING OUTSIDE LIVER** *[PRETEXT STAGING SYSTEM STAGE (OUTSIDE LIVER)]*	an1	R

PRETEXT STAGING SYSTEM STAGE: Pretext 1 – 4 refers to sectors of liver involved.

1	Stage 1: tumour involves only 1 quadrant
2	Stage 2: tumour involves 2 adjoining quadrants; 2 adjoining sections free
3	Stage 3: tumour involves 3 adjoining quadrants; only 1 quadrant free or 2 non-adjoining quadrants free
4	Stage 4: tumour involves all 4 quadrants

PRETEXT STAGING OUTSIDE LIVER: Additional Pretext staging used to describe disease outside the liver.

V	"extension" into the vena cava and/or all three hepatic veins
P	"extension" into the main and/or both left and right branches of the portal vein
E	extra-hepatic disease
M	presence of distant metastases

5.24 CTYA - RENAL PATHOLOGY (Paediatric Kidney)

To carry Pathology details for CTYA.

This section can be recorded more than once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CT6690	CTYA - RENAL PATHOLOGY (Paediatric Kidney)	**INVESTIGATION RESULT DATE**	an10 ccyy-mm-dd	M
CT6700	CTYA - RENAL PATHOLOGY (Paediatric Kidney)	**SERVICE REPORT IDENTIFIER**	max an18	R
CT6610	CTYA - RENAL PATHOLOGY (Paediatric Kidney)	**TUMOUR RUPTURE** *[TUMOUR RUPTURE INDICATOR]*	an1	R
CT6620	CTYA - RENAL PATHOLOGY (Paediatric Kidney)	**ANAPLASTIC NEPHROBLASTOMA** *[ANAPLASTIC NEPHROBLASTOMA TYPE]*	an1	R
CT6630	CTYA - RENAL PATHOLOGY (Paediatric Kidney)	**PERIRENAL FAT INVASION** *[TUMOUR INVASION INDICATOR (PERIRENAL FAT)]*	an1	R
CT6640	CTYA - RENAL PATHOLOGY (Paediatric Kidney)	**RENAL SINUS INVASION** *[TUMOUR INVASION INDICATOR (RENAL SINUS)]*	an1	R

CT6650	CTYA - RENAL PATHOLOGY (Paediatric Kidney)	**RENAL VEIN TUMOUR** *[RENAL VEIN TUMOUR INDICATOR]*	an1	R
CT6660	CTYA - RENAL PATHOLOGY (Paediatric Kidney)	**VIABLE TUMOUR** *[VIABLE TUMOUR INDICATOR]*	an1	R
CT6670	CTYA - RENAL PATHOLOGY (Paediatric Kidney)	**TUMOUR LOCAL STAGE (PATHOLOGICAL)** *[TUMOUR LOCAL STAGE]*	an1	R

INVESTIGATION RESULT DATE: The date on which an investigation was concluded e.g. the date the result was authorised.

SERVICE REPORT IDENTIFIER: A unique identifier of a SERVICE REPORT.

TUMOUR RUPTURE: Integrity of tumour margins based on pathologist's assessment.

Y	Yes
N	No
X	Not stated

ANAPLASTIC NEPHROBLASTOMA: Is there evidence of anaplasia, focal or diffused, based on established pathological classification.

F	Focal Anaplasia
D	Diffused Anaplasia
U	Uncertain

PERIRENAL FAT INVASION: Are there areas of perirenal fat suspected for tumour infiltration.

Y	Yes
N	No
U	Uncertain

RENAL SINUS INVASION: Is there evidence of invasion of renal sinus by tumour.

Y	Yes
N	No
U	Uncertain

RENAL VEIN TUMOUR: Is there evidence of tumour thrombus in the renal vein.

Y	Yes
N	No
U	Uncertain

VIABLE TUMOUR: Is there evidence of viable tumour in the renal sinus.

Y	Yes
N	No
U	Uncertain

TUMOUR LOCAL STAGE (PATHOLOGICAL): Local stage of the tumour as assessed by pathologist. Classification system used is International Society of Paediatric Oncology (SIOP).

1	Stage I
2	Stage II
3	Stage III

6. GYNAECOLOGY

OVERVIEW

The gynaecological site specific dataset covers all registerable conditions listed below including neoplasms of uncertain or unknown behaviour of the female genital organs (D39). This is a more extensive list of conditions than is routinely required for Cancer Waiting Times submissions.

For in-situ conditions (D06-D07) only the pathology report needs to be submitted. Neither Core nor site-specific Gynae dataset is required at present.

TNM Staging does not need to be collected for Gynaecology cancers.

ICD-10 CODES

Key:

() = if applicable

* = different dataset from CWT group specified

ICD-10 All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C48.1	*Specified parts of peritoneum*	*Sarcoma*	● *			** Sarcoma and Gynaecology Datasets to be collected where applicable.*
C48.2	*Peritoneum, unspecified*	*Sarcoma*	● *			** Sarcoma and Gynaecology Datasets to be collected where applicable.*
C51.0	*Labium majus*	*Gynaecological*	● *			** Gynaecology and Skin Datasets to be collected where applicable.*
C51.1	*Labium minus*	*Gynaecological*	● *			** Gynaecology and Skin Datasets to be collected where applicable.*

C51.2	*Clitoris*	*Gynaecological*	● *			** Gynaecology and Skin Datasets to be collected where applicable.*
C51.8	*Overlapping lesion of vulva*	*Gynaecological*	● *			** Gynaecology and Skin Datasets to be collected where applicable.*
C51.9	*Vulva, unspecified*	*Gynaecological*	● *			** Gynaecology and Skin Datasets to be collected where applicable.*
C52	Malignant neoplasm of vagina	Gynaecological	●			
C53.0	Endocervix	Gynaecological	●			
C53.1	Exocervix	Gynaecological	●			
C53.8	Overlapping lesion of cervix uteri	Gynaecological	●			
C53.9	Cervix uteri, unspecified	Gynaecological	●			
C54.0	Isthmus uteri	Gynaecological	●			
C54.1	Endometrium	Gynaecological	●			
C54.2	Myometrium	Gynaecological	●			
C54.3	Fundus uteri	Gynaecological	●			
C54.8	Overlapping lesion of corpus uteri	Gynaecological	●			
C54.9	Corpus uteri, unspecified	Gynaecological	●			
C55	Malignant neoplasm of uterus, part unspecified	Gynaecological	●			
C56	Malignant neoplasm of ovary	Gynaecological	●			
C57.0	Fallopian tube	Gynaecological	●			
C57.1	Broad ligament	Gynaecological	●			
C57.2	Round ligament	Gynaecological	●			
C57.3	Parametrium	Gynaecological	●			
C57.4	Uterine adnexa, unspecified	Gynaecological	●			
C57.7	Other specified female genital organs	Gynaecological	●			

C57.8	Overlapping lesion of female genital organs	Gynaecological	●			
C57.9	Female genital organ, unspecified	Gynaecological	●			
C58	Malignant neoplasm of placenta	Gynaecological	●			
C79.6	Secondary malignant neoplasm of ovary	Gynaecological		●		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
D06.0	carcinoma in situ of endocervix	Gynaecological			●	
D06.1	carcinoma in situ of exocervix	Gynaecological			●	
D06.7	carcinoma in situ of other parts of cervix	Gynaecological			●	
D06.9	carcinoma in situ of cervix, unspecified	Gynaecological			●	
D07.0	carcinoma in situ of endometrium	Gynaecological			●	
D07.1	carcinoma in situ of vulva	Gynaecological			●	
D07.2	carcinoma in situ of vagina	Gynaecological			●	
D07.3	carcinoma in situ of other and unspecified female genital organs	Gynaecological			●	
D39.0	Neoplasm of uncertain or unknown behaviour of Uterus	Gynaecological			●	
D39.1	Neoplasm of uncertain or unknown behaviour of Ovary	Gynaecological			●	
D39.2	Neoplasm of uncertain or unknown behaviour of Placenta	Gynaecological			●	

D39.7	Neoplasm of uncertain or unknown behaviour of Other female genital organs	Gynaecological			●	
D39.9	Neoplasm of uncertain or unknown behaviour of Female genital organ, unspecified	Gynaecological			●	

6.1 GYNAECOLOGY – SURGERY

To carry surgery and other procedure details for Gynae.
This section will be recorded once per treatment where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
GY7000	GYNAECOLOGY - SURGERY	**SURGEON GRADE** *[CARE PROFESSIONAL SENIOR OPERATING SURGEON GRADE (CANCER)]*	an1	M

SURGEON GRADE: Grade of senior surgeon present at operation.

S	Sub-specialist Gynaecological Oncologist
C	Consultant Gynaecologist (not sub-specialist)
F	Sub-Specialty Fellow
A	Associate Specialist / Staff Grade
R	SPR / ST3+
O	SHO / ST1 or ST2
G	General Surgeon / other surgical specialty

6.2 GYNAECOLOGY – STAGING

To carry staging details for Gynae.
This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
GY7010	GYNAECOLOGY - STAGING	**FINAL FIGO STAGE**	max an5	M

FINAL FIGO STAGE: The FIGO stage is generally confirmed at pathology review in MDT meetings following surgery for uterine and vulval malignancies and for ovarian malignancies undergoing primary surgery.
For ovarian malignancies planned to undergo neoadjuvant chemotherapy and for cases of cervical cancer (which is staged clinically), the final FIGO stage is determined at the time of review of clinical findings, imaging, cytology and biopsy histology at the MDT meeting.
FIGO Stage groups for gynaecological cancers are as follows:

VULVAL

FIGO Stage Group	*Description*
	Stage I : Tumour confined to the vulva
IA	Lesions ≤2 cm in size, confined to the vulva or perineum and with stromal invasion ≤1.0 mm, no nodal metastasis.
IB	Lesions ≥ 2 cm in size or with stromal invasion >1.0 mm*, confined to the vulva or perineum, with negative nodes
	Stage2:
II	Tumour of any size with extension to adjacent perineal structures (1/3 lower urethra, 1/3 lower vagina, anus) with negative nodes
	Stage III : Tumour of any size with or without extension to adjacent perineal structures ((1/3 lower urethra, 1/3 lower vagina, anus) with positive inguino-femoral lymph nodes
IIIAi	(i) With 1 lymph node metastasis (≥5 mm) or
IIIAii	(ii) 1–2 lymph node metastasis(es) (<5 mm)
IIIBi	With 2 or more lymph node metastases (≥5 mm), or
IIIBii	3 or more lymph node metastases (<5 mm)
IIIC	With positive nodes with extracapsular spread
	Stage IV : Tumour invades other regional (2/3 upper urethra, 2/3 upper vagina) or distant structures
IVAi	Tumour invades any of the following: upper urethral and/or vaginal mucosa, bladder mucosa, rectal mucosa, or fixed to pelvic bone or
IVAii	fixed or ulcerated inguino-femoral lymph nodes
IVB	Any distant metastasis including pelvic lymph nodes

CERVICAL

FIGO Stage Group	*Description*
	Stage I : The carcinoma is strictly confined to the cervix (extension to the corpus would be disregarded)
	Stage lA : Invasive carcinoma which can be diagnosed only by microscopy with deepest invasion ≤5mm and largest extension ≥7mm
IA1	Measured stromal invasion ≤3.0mm in depth and extension of ≤7.0mm.
IA2	Measured stromal invasion >3.0mm and not >5.0mm with an extension of of not >7.0mm
	Stage lB: Clinically visible lesion confined to the cervix or pre-clinical cancers greater than stage IA
IB1	Clinically visible lesion ≤4.0cm in greatest dimension
IB2	Clinically visible lesion ≥4.0cm in greatest dimension
	Stage ll : Cervical carcinoma invades beyond the uterus but not to pelvic wall or to lower third of vagina
	Stage llA: Without parametrial invasion
IIA1	Clinically visible lesion ≤4.0cm in greatest dimension
IIA2	Clinically visible lesion >4.0cm in greatest dimension
IIB	Tumour with parametrial invasion
	Stage lll : Tumour extends to pelvic wall and/or involves lower third of vagina and/or causes hydronephrosis or non-functioning kidney
IIIA	Tumour involves lower third of vagina with no extension to the pelvic wall

IIIB	Tumour extends to pelvic wall and/or hydronephrosis or non-functioning kidney
	Stage IV : The carcinoma has extended beyond the true pelvis or has involved (biopsy proven) the mucosa of the bladder or rectum. A bullous edema, as such, does not permit a case to be allotted to Stage IV
IVA	Spread of the tumour to adjacent organs
IVB	Spread to distant organs

ENDOMETRIAL

FIGO Stage Group	***Description***
	Stage I : Tumour confined to corpus uteri
IA	No or < half myometrial invasion
IB	Invasion equal to or more than half of the myometrium
II	Tumour invades cervical stroma but does not extend beyond uterus
	Stage III : Local and/or regional spread of tumour
IIIA	Tumour invades the serosa of the corpus uteri and/or adnexa
IIIB	Vaginal and/or parametrial involvement
IIIC	Metastases to pelvic and/or para-aortic nodes
IIIC1	Positive pelvic nodes
IIIC2	Positive para-aortic nodes with or without positive pelvic lymph nodes
	Stage IV : Tumour invades bladder and/or bowel mucosa
IVA	Tumour invasion of bladder and/or bowel mucosa
IVB	Distant metastases including abdominal metastases and/or inguinal lymph nodes

OVARIAN

FIGO Stage Group	***Description***
IA	Tumour limited to one ovary; capsule intact; no tumour on ovarian surface; no malignant cells in ascites or peritoneal washings
IB	Tumour limited to both ovaries; capsules intact; no tumour on ovarian surface; no malignant cells in ascites or peritoneal washings
IC	Tumour limited to one or both ovaries with any of the following: capsule ruptured, tumour on ovarian surface, malignant cells in the ascites or positive peritoneal washings
IIA	Extension and/or implants on uterus and/or tubes; no malignant cells in the ascites or peritoneal washings
IIB	Extension to other pelvic organ; no malignant cells in the ascites or peritoneal washings
IIC	IIA/B with malignant cells in the ascites or positive peritoneal washings
IIIA	Microscopic peritoneal metastasis beyond the pelvis
IIIB	Macroscopic peritoneal metastasis beyond the pelvis 2 cm or less in greatest dimension
IIIC	Peritoneal metastasis beyond pelvis more than 2 cm in greatest dimension and/or regional lymph node metastasis
IV	Distant metastasis beyond the peritoneal cavity *(excludes peritoneal metastasis)*

FALLOPIAN TUBE

FIGO Stage Group	***Description***
IA	Tumour limited to one tube, without penetrating the serosal surface
IB	Tumour limited to both tubes, without penetrating the serosal surface
IC	Tumour limited to one or both tubes, with extension onto/through the tubal serosa; or with malignant cells in the ascites or positive peritoneal washings
IIA	Extension and/or metastasis to uterus and/or ovaries
IIB	Extension to other pelvic structures
IIC	Pelvic extension (IIA/B) with malignant cells in the ascites or positive peritoneal washings
IIIA	Microscopic peritoneal metastasis outside the pelvis
IIIB	Macroscopic peritoneal metastasis outside the pelvis 2 cm or less in greatest dimension
IIIC	Peritoneal metastasis more than 2cm in greatest dimension and/or positive regional lymph nodes
IV	Distant metastasis beyond the peritoneal cavity (excludes peritoneal metastasis)

LEIOMYOSARCOMAS AND ENDOMETRIAL STROMAL SARCOMAS

FIGO Stage Group	***Description***
IA	Tumour limited to uterus and 5cm or less in greatest dimension
IB	Tumour limited to uterus and greater than 5cm in greatest dimension
IIA	Tumour extends to pelvis with adnexal involvement
IIB	Involvement of other pelvic tissues
IIIA	Tumour invades abdominal tissues, one site
IIIB	Tumour invades abdominal tissues, more than one site
IIIC	Metastasis to pelvic and/or para-aortic lymph nodes
IVA	Tumour invades bladder and/or rectum
IVB	Distant metastasis

ADENOSARCOMAS

FIGO Stage Group	***Description***
IA	Tumour limited to endometrium/endocervix with no myometrial invasion
IB	Less than or equal to half myometrial invasion*
IC	More than half myometrial invasion*
IIA	Adnexal involvement
IIB	Involvement of other pelvic tissue
IIIA	Tumour invades abdominal tissues, one site
IIIB	Tumour invades abdominal tissues, more than one site
IIIC	Metastasis to pelvic and/or para-aortic lymph nodes
IVA	Tumour invades bladder and/or rectum
IVB	Distant metastasis

6.3 GYNAECOLOGY – PATHOLOGY

To carry pathology details for Gynae.
This section can be recorded more than once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
GY7320	GYNAECOLOGY - PATHOLOGY	**INVESTIGATION RESULT DATE**	an10 ccyy-mm-dd	M
GY7430	GYNAECOLOGY - PATHOLOGY	**SERVICE REPORT IDENTIFIER**	max an18	R
GY7050	GYNAECOLOGY - PATHOLOGY	**FALLOPIAN TUBE INVOLVEMENT** *[MICROSCOPIC INVOLVEMENT INDICATION CODE (FALLOPIAN TUBE)]*	an1	R
GY7120	GYNAECOLOGY - PATHOLOGY	**OVARIAN INVOLVEMENT** *[MICROSCOPIC INVOLVEMENT INDICATION CODE (OVARIAN)]*	an1	R
GY7130	GYNAECOLOGY - PATHOLOGY	**SEROSAL INVOLVEMENT** *[MICROSCOPIC INVOLVEMENT INDICATOR (SEROSA)]*	an1	R
GY7100	GYNAECOLOGY - PATHOLOGY	**OMENTAL INVOLVEMENT** *[OMENTUM INVOLVEMENT INDICATION CODE]*	an1	R

INVESTIGATION RESULT DATE: The date on which an investigation was concluded e.g. the date the result was authorised.
SERVICE REPORT IDENTIFIER: A unique identifier of a SERVICE REPORT.

FALLOPIAN TUBE INVOLVEMENT: For endometrial and epithelial/ovarian cancers, is there microscopic involvement of fallopian tubes?

1	Not involved
2	Right involved
3	Left involved
4	Both involved
X	Not assessable

OVARIAN INVOLVEMENT: For endometrial and fallopian cancers, is there microscopic involvement of ovaries?

1	Not involved
2	Right involved
3	Left involved
4	Both involved
X	Not assessable

SEROSAL INVOLVEMENT: For endometrial, epithelial/ovarian and fallopian cancers, is there microscopic involvement of uterine serosa?

Y	Yes
N	No
X	Not assessable

OMENTAL INVOLVEMENT: For endometrium, ovary, fallopian tube and primary peritoneum cancers, is there involvement of the omentum?

1	Involved - deposit size not specified
2	Involved - deposit(s) 20mm or less
3	Involved - deposit(s) greater than 20mm
4	Not involved
X	Not assessable/not sent

6.4 GYNAECOLOGY – PATHOLOGY – FALLOPIAN TUBE, OVARIAN EPITHELIAL and PRIMARY PERITONEAL

To carry pathology details for Gynae for Fallopian Tube, Ovarian Epithelial and Primary Peritoneal.
This section will be recorded once per pathology report where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
GY7140	GYNAECOLOGY - PATHOLOGY - FALLOPIAN TUBE, OVARIAN EPITHELIAL and PRIMARY PERITONEAL	**CAPSULE STATUS**	an1	R
GY7190	GYNAECOLOGY - PATHOLOGY - FALLOPIAN TUBE, OVARIAN EPITHELIAL and PRIMARY PERITONEAL	**OVARIAN SURFACE INVOLVEMENT** *[OVARY SURFACE INVOLVEMENT INDICATOR]*	an1	R
GY7150	GYNAECOLOGY - PATHOLOGY - FALLOPIAN TUBE, OVARIAN EPITHELIAL and PRIMARY PERITONEAL	**TUMOUR GRADE** *[TUMOUR GRADE (GYNAECOLOGY]*	an1	R
GY7170	GYNAECOLOGY - PATHOLOGY - FALLOPIAN TUBE, OVARIAN EPITHELIAL and PRIMARY PERITONEAL	**PERITONEAL CYTOLOGY** *[PERITONEAL CYTOLOGY RESULT CODE]*	an1	R
GY7180	GYNAECOLOGY - PATHOLOGY - FALLOPIAN TUBE, OVARIAN EPITHELIAL and PRIMARY PERITONEAL	**PERITONEAL INVOLVEMENT** *[PERITONEAL INVOLVEMENT INDICATOR]*	an1	R

CAPSULE STATUS: Capsule status of ovaries (record the most severe)

1	Intact
2	Disrupted
3	Involved
X	Not assessable

OVARIAN SURFACE INVOLVEMENT: Is there involvement of the surface of either ovary?

Y	Yes
N	No
X	Not assessable

TUMOUR GRADE: Specify the grade of the tumour. For serous tumours specify whether High or Low grade; clear cell carcinomas and carcinosarcomas are all high grade; for all other tumours use three tier grading system.

L	Low
I	Intermediate
H	High

PERITONEAL CYTOLOGY: Result of peritoneal cytology.

1	Involved
2	Not involved
3	Equivocal
X	Not sent

PERITONEAL INVOLVEMENT: Is there peritoneal involvement?

Y	Yes
N	No
X	Not assessable / Not sent

6.5 GYNAECOLOGY – PATHOLOGY – ENDOMETRIAL

To carry pathology details for Gynae for Endometrial.
This section will be recorded once per pathology report where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
GY7210	GYNAECOLOGY - PATHOLOGY - ENDOMETRIAL	**BACKGROUND ENDOMETRIUM** *[BACKGROUND ENDOMETRIUM ABNORMALITY INDICATION CODE]*	an1	R
GY7220	GYNAECOLOGY - PATHOLOGY - ENDOMETRIAL	**DISTANCE TO SEROSA**	max n2	R
GY7240	GYNAECOLOGY - PATHOLOGY - ENDOMETRIAL	**INVOLVEMENT OF CERVICAL STROMA** *[MICROSCOPIC INVOLVEMENT INDICATOR (CERVICAL STROMA)]*	an1	R
GY7250	GYNAECOLOGY - PATHOLOGY - ENDOMETRIAL	**INVOLVEMENT OF CERVICAL SURFACE OR GLANDS** *[MICROSCOPIC INVOLVEMENT INDICATOR (CERVICAL SURFACE OR GLANDS)]*	an1	R
GY7260	GYNAECOLOGY - PATHOLOGY - ENDOMETRIAL	**MYOMETRIAL INVASION** *[MYOMETRIAL INVASION IDENTIFICATION CODE]*	an1	R
GY7270	GYNAECOLOGY - PATHOLOGY - ENDOMETRIAL	**PARAMETRIUM INVOLVEMENT** *[MICROSCOPIC INVOLVEMENT INDICATOR (PARAMETRIUM)]*	an1	R

GY7280	GYNAECOLOGY - PATHOLOGY - ENDOMETRIAL	**PERITONEAL WASHINGS** *[PERITONEAL WASHINGS IDENTIFIED]*	an1	R

BACKGROUND ENDOMETRIUM: Are abnormalities present in the background endometrium?

N	Normal
A	Abnormal
X	Not assessable

DISTANCE TO SEROSA: Specify the tumour free distance to the serosa in millimetres (mm's).

INVOLVEMENT OF CERVICAL STROMA: Is there microscopic involvement of cervical stroma?

Y	Yes
N	No
X	Not assessable

INVOLVEMENT OF CERVICAL SURFACE OR GLANDS: Is there microscopic involvement of endocervical surface or crypt epithelium?

Y	Yes
N	No
X	Not assessable

MYOMETRIAL INVASION: Is there microscopic evidence of myometrial invasion?

1	None
2	Less than 50%
3	Greater than or equal to 50%

PARAMETRIUM INVOLVEMENT: Is there microscopic involvement of parametrium?

Y	Yes
N	No
X	Not assessable

PERITONEAL WASHINGS: Were peritoneal washings submitted and if so were malignant cells seen?

1	Positive
2	Negative
X	Not sent/Not assessable

6.6 GYNAECOLOGY – PATHOLOGY - CERVICAL

To carry pathology details for Gynae for Cervical.
This section will be recorded once per pathology report where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
GY7290	GYNAECOLOGY - PATHOLOGY - CERVICAL	**CGIN GRADE** *[CERVICAL GLANDULAR INTRAEPITHELIAL NEOPLASIA PRESENCE AND GRADE]*	an1	R
GY7300	GYNAECOLOGY - PATHOLOGY - CERVICAL	**CIN GRADE** *[CERVICAL INTRAEPITHELIAL NEOPLASIA PRESENCE AND GRADE]*	an1	R
GY7350	GYNAECOLOGY - PATHOLOGY - CERVICAL	**SMILE** *[SMILE INDICATION CODE]*	an1	R
GY7310	GYNAECOLOGY - PATHOLOGY - CERVICAL	**EXCISION MARGIN (PRE INVASIVE)** *[RESECTION MARGIN INVOLVEMENT INDICATOR]*	an1	R
GY7330	GYNAECOLOGY - PATHOLOGY - CERVICAL	**INVASIVE THICKNESS**	max n2.max n2	R
GY7340	GYNAECOLOGY - PATHOLOGY - CERVICAL	**PARACERVICAL OR PARAMETRIAL INVOLVEMENT** *[PARACERVICAL OR PARAMETRIAL INVOLVEMENT INDICATOR]*	an1	R
GY7360	GYNAECOLOGY - PATHOLOGY - CERVICAL	**THICKNESS UNINVOLVED STROMA** *[UNINVOLVED CERVICAL STROMA THICKNESS]*	max n2.max n2	R
GY7370	GYNAECOLOGY - PATHOLOGY - CERVICAL	**VAGINAL INVOLVEMENT** *[MICROSCOPIC INVOLVEMENT INDICATOR (VAGINAL)]*	an1	R

CGIN GRADE: Specify presence and grade of CGIN (cervical glandular intraepithelial neoplasia)

1	Low
2	High
3	Not present
X	Not assessable

CIN GRADE: Specify presence and grade of CIN (cervical intra-epithelial neoplasia)

1	1
2	2
3	3
4	Not present
X	Not assessable

SMILE: Specify presence of SMILE (Stratified Mucin-Producing Intra-Epithelial Lesion)

1	Present

2	Absent
X	Not assessable

EXCISION MARGIN (PRE INVASIVE): Is there evidence of resection margin involvement by in situ/pre invasive disease (CIN, CGIN, and SMILE)

Y	Yes
N	No
X	Not assessable

INVASIVE THICKNESS: The thickness or depth of the invasive lesion in millimetres (mm).
Note: For COSD reporting purposes, this data item is not required to be submitted to two decimal places.

PARACERVICAL OR PARAMETRIAL INVOLVEMENT: Is there evidence of paracervical and/or parametrial involvement?

Y	Yes
N	No
X	Not assessable

THICKNESS UNINVOLVED STROMA: Minimum thickness of uninvolved cervical stroma in millimetres (mm) (minimum tumour-free rim).
Note: For COSD reporting purposes, this data item is not required to be submitted to two decimal places.

VAGINAL INVOLVEMENT: Is there evidence of microscopic vaginal involvement?

Y	Yes
N	No
X	Not assessable

6.7 GYNAECOLOGY – PATHOLOGY – VULVAL

To carry pathology details for Gynae for Vulval.
This section will be recorded once per pathology report where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
GY7390	GYNAECOLOGY - PATHOLOGY - VULVAL	**INVASIVE THICKNESS**	max n2.max n2	R

INVASIVE THICKNESS: The thickness or depth of the invasive lesion in millimetre's (mm's).
Note: For COSD reporting purposes, this data item is not required to be submitted to two decimal places.

6.8 GYNAECOLOGY – PATHOLOGY – NODES

To carry pathology details for Gynae for Nodes.
This section will be recorded once per pathology report where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)

GY7020	GYNAECOLOGY - PATHOLOGY - NODES	**NODAL STATUS CERVICAL CANCER** *[CERVICAL NODE STATUS]*	an2	R
GY7060	GYNAECOLOGY - PATHOLOGY - NODES	**NODES EXAMINED NUMBER (PARA-AORTIC)** *[NUMBER OF NODES EXAMINED (PARA-AORTIC)]*	max n2	R
GY7080	GYNAECOLOGY - PATHOLOGY - NODES	**NODES POSITIVE NUMBER (PARA-AORTIC)** *[NUMBER OF NODES POSITIVE (PARA-AORTIC)]*	max n2	R
GY7070	GYNAECOLOGY - PATHOLOGY - NODES	**NODES EXAMINED NUMBER (PELVIC)** *[NUMBER OF NODES EXAMINED (PELVIC)]*	max n2	R
GY7090	GYNAECOLOGY - PATHOLOGY - NODES	**NODES POSITIVE NUMBER (PELVIC)** *[NUMBER OF NODES POSITIVE (PELVIC)]*	max n2	R
GY7410	GYNAECOLOGY - PATHOLOGY - NODES	**NODES EXAMINED NUMBER (INGUINO-FEMORAL)** *[NUMBER OF NODES EXAMINED (INGUINO-FEMORAL)]*	max n2	R
GY7420	GYNAECOLOGY - PATHOLOGY - NODES	**NODES POSITIVE NUMBER (INGUINO-FEMORAL)** *[NUMBER OF NODES POSITIVE (INGUINO-FEMORAL)]*	max n2	R
GY7230	GYNAECOLOGY - PATHOLOGY - NODES	**EXTRANODAL SPREAD** *[EXTRANODAL SPREAD INDICATOR]*	an1	R

NODAL STATUS CERVICAL CANCER: FOR CERVICAL CANCERS ONLY. Only required for surgically staged early FIGO stage cancers. Histological assessment of regional lymph nodes, including surgical excision or fine needle aspiration. (FIGO staging for cervical cancer is clinical, but nodal status may be an important prognostic factor and determinant of management options including the need for adjuvant therapy). This could be derived from NODES EXAMINED NUMBER (PELVIC) and NODES POSITIVE NUMBER (PELVIC) but may also be entered separately.

NX	Regional lymph nodes cannot be assessed
N0	No regional lymph node metastases
N1	Regional lymph node metastases

NODES EXAMINED NUMBER (PARA-AORTIC): The number of para-aortic nodes examined. (Not applicable for vulval cancers) Use 0 if nodes not sent.

NODES POSITIVE NUMBER (PARA-AORTIC): The number of para-aortic nodes reported as being positive for the presence of tumour metastases. (Not applicable for vulval cancers)

NODES EXAMINED NUMBER (PELVIC): The number of pelvic nodes examined (Not applicable for vulval cancers). Use 0 if nodes not sent

NODES POSITIVE NUMBER (PELVIC): The number of pelvic nodes reported as being positive for the presence of tumour metastases. (Not applicable for vulval cancers)

NODES EXAMINED NUMBER (INGUINO-FEMORAL): The number of inguino-femoral nodes examined. (Only applicable to vulval cancers). Use 0 if nodes not sent

NODES POSITIVE NUMBER (INGUINO-FEMORAL): The number of inguino-femoral nodes reported as being positive for the presence of tumour metastases. (Only applicable to vulval cancers)

EXTRANODAL SPREAD: Is there evidence of extranodal spread/extension?

Y	Yes
N	No
X	Not accessable

7. HAEMATOLOGY

OVERVIEW

In order to ensure that all the data items can be collected it is essential to discuss the process with clinicians responsible for treating the patients.

For all haematology patients it is essential to record the ICD03 MORPHOLOGY CODE (see Core Dataset).

7.1 STAGE

TNM Staging is not collected for Haematological cancers. However the following staging data items are required for all relevant cases:

CLL: Rai stage and Binet stage (including all component data items). This is to enable comparison as neither stage is used exclusively. Both can be derived if components are recorded.

Myeloma; ISS

All Lymphomas: Ann Arbor Stage, Ann Arbor Symptoms, Ann Arbor Extranodality and Ann Arbor Bulk

Additionally, the following prognostic indicators are also required:

CML: Hasford Index and Sokal index (including all component data items). This is to enable comparison as neither index is used exclusively. Both can be calculated if components are recorded.

Myelodysplasia: IPSS

Follicular lymphoma: FLIPI index

DLBCL: (R)IPI index

Hodgkin Lymphoma: Hasenclever index (Only applicable to advanced Stage 3 and 4 disease)

7.2 ICD CODES AND WHO DISEASE GROUPS

The following table shows the full list of ICD10 codes which are applicable for Haematology mapped against the relevant ICDO3 codes as well as the dataset which should be completed for each disease and the WHO Disease Group. (Please see Appendix C for Description of Disease Groups). Changes from Version 1.9 of the User Guide are shown in red.

IMPORTANT NOTE: Where a suffix has been added this should be used consistently as shown to ensure that diseases with the same ICDO3 code can be correctly distinguished. To ensure that consistent coding continues to be applied nationally, please advise the COSD team if you identify potential changes or additional coding requirements. (For visual clarity the ICDO3 codes in the table are formatted differently from the specification. Records should be submitted according to the format in the specification, either “MXXXXX”, or “MXXXXXX” with suffix)

Where marked as “CORE ONLY” there is no disease specific dataset so only the core dataset will be completed. Please also note that every record must include the relevant ICDO3 code.

LYMPHOBLASTIC LEUKAEMIA/LYMPHOBLASTIC LYMPHOMA CODING

Lymphoblastic lymphoma and lymphoblastic leukaemia are now known to be the same entity. This is reflected in the latest ICDO3 coding update which assigns the same morphology code to both and uses the combined term 'lymphoblastic leukaemia/lymphoma'. Historically different codes were assigned to lymphoblastic

lymphoma and leukaemia and ICD10 coding still distinguishes between these two groups. The coding list below therefore retains the separate ICD10 codes (C83.5 and C91.0) but assigns the same ICDO3 codes to each pair of diseases. (Further detail can be provided if required.)

RECORDING AMYLOIDOSIS FOR COSD

The aim is to register patients presenting with symptoms referable to an underlying diagnosis of amyloidosis in the absence of a known, registerable plasma cell or lymphoid neoplasm.

Amyloidosis may be associated with plasma cell neoplasms such as multiple myeloma, other B cell neoplasms (such as lymphoplasmacytic lymphoma), or with paraproteinaemias (which are not associated with identified myeloma or lymphoma (i.e. MGUS).

If amyloidosis is identified in association with a registerable condition (such as multiple myeloma, plasmacytoma, lymphoplasmacytic lymphoma, Waldenstroms macroglobulinaemia etc), only the data for the associated registerable condition should be submitted through COSD and this will be registered as a new diagnosis by the cancer registries. Amyloidosis should not be submitted for COSD in these circumstances.

Amyloid deposition associated with chronic infection, medullary carcinoma of the thyroid, insulinoma, prolactinoma, Alzheimer disease, prion diseases and other non-AL types of amyloid, is considered to be secondary amyloidosis and should not be submitted for COSD.

If amyloidosis is identified in the absence of a registerable condition or before the identification of a registerable condition, then data for Primary Amyloidosis* should be submitted for COSD and this will be registered as a new diagnosis by the cancer registries.

Please note that for the purpose of COSD, MGUS (monoclonal gammopathy of unknown significance) is not a registerable disease and therefore amyloidosis associated with a paraprotein/MGUS should be submitted for COSD and will be registered as a new diagnosis.

Amyloidosis as identified above should be recorded for COSD and coded as follows:

ICD10 code: E85.9 (Amyloidosis unspecified)

ICDO3 morphology code: M9769/1

*Primary Amyloidosis is composed of abnormal immunoglobulin light chains (or rarely heavy chains) which deposit (either intact or in fragments) in various tissues. These form B-pleated sheets (AL amyloid) that bind Congo Red dye with characteristic birefringence.

ICD-O-3	ICD-O-3 WHO Description	ICD-10 (4th Edition)	ICD10 Description	Clinical dataset	WHO DISEASE GROUP
9591/3	Malignant lymphoma, non-Hodgkin, NOS	C85.9	Non-Hodgkin lymphoma, unspecified	Other Lymphomas	(No applicable group)
9591/3 A	Hairy cell leukaemia variant	C85.1	B-cell lymphoma, unspecified	Other Lymphomas	9
9591/3 B	Splenic diffuse red pulp small B-cell lymphoma	C85.1	B-cell lymphoma, unspecified	Other Lymphomas	9
9591/3 C	Splenic B-cell lymphoma/leukaemia, unclassifiable	C85.1	B-cell lymphoma, unspecified	Other Lymphomas	9
9591/3 D	B cell lymphoma, NOS	C85.1	B-cell lymphoma, unspecified	Other Lymphomas	9
9596/3	B-cell lymphoma, intermediate between DLBCL/Classical Hodgkins	C85.1	B-cell lymphoma, unspecified	Other Lymphomas	9
9597/3	Primary cutaneous follicle centre lymphoma	C82.6	Cutaneous follicle centre lymphoma	Follicular	9
9650/3	Classical Hodgkin lymphoma	C81.9	Hodgkin lymphoma, unspecified	Hodgkin	11

ICD-O-3	ICD-O-3 WHO Description	ICD-10 (4th Edition)	ICD10 Description	Clinical dataset	WHO DISEASE GROUP
9651/3	Lymphocyte-rich classical Hodgkin lymphoma	C81.4	Lymphocyte-rich classical Hodgkin lymphoma	Hodgkin	11
9652/3	Mixed cellularity classical Hodgkin lymphoma	C81.2	Mixed cellularity classical Hodgkin lymphoma	Hodgkin	11
9653/3	Lymphocyte-depleted classical Hodgkin lymphoma	C81.3	Lymphocytic depleted classical Hodgkin lymphoma	Hodgkin	11
9659/3	Nodular lymphocyte predominant Hodgkin lymphoma	C81.0	Nodular lymphocyte predominant Hodgkin lymphoma	Hodgkin	11
9663/3	Nodular sclerosis classical Hodgkin lymphoma	C81.1	Nodular sclerosis classical Hodgkin lymphoma	Hodgkin	11
9671/3	Lymphoplasmacytic lymphoma	C83.3	Diffuse large B-cell lymphoma	Other Lymphomas	9
9673/3	Mantle cell lymphoma	C83.1	Mantle cell lymphoma	Other Lymphomas	9
9678/3	Primary effusion lymphoma	C83.3	Diffuse large B-cell lymphoma	Other Lymphomas	9
9679/3	Primary mediastinal (thymic) large B-cell lymphoma	C85.2	Mediastinal (thymic)large B-cell lymphoma	Other Lymphomas	9
9680/3	Diffuse large B-cell lymphoma (DLBCL), NOS	C83.3	Diffuse large B-cell lymphoma	DLBCL	9
9680/3 A	Primary DLBCL of the CNS	C83.3	Diffuse large B-cell lymphoma	DLBCL	9
9680/3 B	EBV positive DLBCL of the elderly	C83.3	Diffuse large B-cell lymphoma	DLBCL	9
9680/3 C	B-cell lymphoma, intermediate between DLBCL /Burkitt lymphoma	C83.3	Diffuse large B-cell lymphoma	DLBCL	9
9680/3 D	Primary cutaneous DLBCL, leg type	C83.3	Diffuse large B-cell lymphoma	DBLCL	9
9680/3 E	DLBCL associated with chronic inflammation	C83.3	Diffuse large B-cell lymphoma	DLBCL	9
9687/3	Burkitt lymphoma	C83.7	Burkitt lymphoma	Other Lymphomas	9
9688/3	T-cell/histiocyte rich large B-cell lymphoma	C83.3	Diffuse large B-cell lymphoma	Other Lymphomas	9
9689/3	Splenic marginal zone lymphoma	C83.0	Small cell B-cell lymphoma	Other Lymphomas	9
9690/3	Follicular lymphoma	C82.9	Follicular lymphoma, unspecified	Follicular	9
9691/3	Follicular lymphoma Grade 2	C82.1	Follicular lymphoma grade II	Follicular	9
9695/3	Follicular lymphoma Grade 1	C82.0	Follicular lymphoma grade I	Follicular	9
9698/3	Follicular lymphoma Grade 3	C82.2	Follicular lymphoma grade III, unspecified	Follicular	9
9698/3 A	Follicular lymphoma Grade 3A	C82.3	Follicular lymphoma grade IIIa	Follicular	9
9698/3 B	Follicular lymphoma Grade 3B	C82.4	Follicular lymphoma grade IIIb	Follicular	9
9699/3 A	Extranodal marginal zone lymphoma of mucosa-associated lymphoid tissue (MALT)	C88.4	Extranodal marginal zone B-cell lymphoma of mucosa-associated lymphoid tissue [MALT-lymphoma]	Other Lymphomas	9
9699/3 B	Nodal marginal zone lymphoma	C83.0	Small cell B-cell lymphoma	Other Lymphomas	9
9700/3	Mycosis fungoides	C84.0	Mycosis fungoides	Other Lymphomas	10

ICD-O-3	ICD-O-3 WHO Description	ICD-10 (4th Edition)	ICD10 Description	Clinical dataset	WHO DISEASE GROUP
9701/3	Sézary syndrome	C84.1	Sézary disease	Other Lymphomas	10
9702/3 A	Peripheral T-cell lymphoma, NOS	C84.4	Peripheral T-cell lymphoma, not elsewhere classified	Other Lymphomas	10
9702/3 B	Anaplastic large cell lymphoma, ALK negative	C84.7	Anaplastic large cell lymphoma, ALK-negative	Other Lymphomas	10
9705/3	Angioimmunoblastic T-cell lymphoma	C86.5	Angioimmunoblastic T-cell lymphoma	Other Lymphomas	10
9708/3	Subcutaneous panniculitis-like T-cell lymphoma	C86.3	Subcutaneous panniculitis-like T-cell lymphoma	Other Lymphomas	10
9709/3 A	Primary cutaneous CD8+ aggressive epidermotropic cytotoxic T-cell lymphoma	C84.8	Cutaneous T-cell lymphoma, unspecified	Other Lymphomas	10
9709/3 B	Primary cutaneous CD4 positive small/medium T-cell lymphoma	C84.8	Cutaneous T-cell lymphoma, unspecified	Other Lymphomas	10
9712/3	Intravascular large B-cell lymphoma	C83.3	Diffuse large B-cell lymphoma	Other Lymphomas	9
9714/3	Anaplastic large cell lymphoma, ALK positive	C84.6	Anaplastic large cell lymphoma, ALK-positive	Other Lymphomas	10
9716/3	Hepatosplenic T-cell lymphoma	C86.1	Hepatosplenic T-cell lymphoma	Other Lymphomas	10
9717/3	Enteropathy-associated T-cell lymphoma	C86.2	Enteropathy-type (intestinal) T-cell lymphoma	Other Lymphomas	10
9718/3	Primary cutaneous anaplastic large cell lymphoma	C86.6	Primary cutaneous CD30-positive T-cell proliferations	Other Lymphomas	10
9719/3	Extranodal NK/T cell lymphoma, nasal type	C86.0	Extranodal NK/T-cell lymphoma, nasal type	Other Lymphomas	10
9719/3 A	T/NK-cell lymphoma	C84.9	Mature T/NK-cell lymphoma, unspecified	CORE ONLY	10
9724/3	Systemic EBV positive T-cell lymphoproliferative disease of childhood	C84.5	Other mature T/NK-cell lymphomas	Other Lymphomas	10
9725/3	Hydroa vacciniforme-like lymphoma	C84.5	Other mature T/NK-cell lymphomas	Other Lymphomas	10
9726/3	Primary cutaneous gamma-delta T-cell lymphoma	C84.5	Other mature T/NK-cell lymphomas	Other Lymphomas	10
9727/3	Blastic plasmacytoid dendritic cell neoplasm	C86.4	Blastic NK-cell lymphoma	Other Lymphomas	5
9729/3	T lymphoblastic lymphoma	C83.5	Lymphoblastic (diffuse) lymphoma	ALL	8
9731/3	Solitary plasmacytoma of bone	C90.3	Solitary plasmacytoma	CORE ONLY	9
9732/3	Plasma cell myeloma	C90.0	Multiple myeloma	Myeloma	9
9733/3	Plasma cell leukaemia	C90.1	Plasma cell leukaemia	Myeloma	9
9734/3	Extraosseous plasmacytoma	C90.2	Extramedullary plasmacytoma	CORE ONLY	9
9735/3	Plasmablastic lymphoma	C83.3	Diffuse large B-cell lymphoma	Other Lymphomas	9
9737/3	ALK positive large B-cell lymphoma	C83.3	Diffuse large B-cell lymphoma	Other Lymphomas	9

ICD-O-3	ICD-O-3 WHO Description	ICD-10 (4th Edition)	ICD10 Description	Clinical dataset	WHO DISEASE GROUP
9738/3	Large B-cell lymphoma arising in HHV8-associated multicentric Castleman disease	C83.3	Diffuse large B-cell lymphoma	Other Lymphomas	9
9740/1 A	Cutaneous mastocytosis	D47.0	Histiocytic and mast cell tumours of uncertain and unknown behaviour	CORE ONLY	1
9740/1 B	Extracutaneous mastocytoma	D47.0	Histiocytic and mast cell tumours of uncertain and unknown behaviour	CORE ONLY	1
9740/3	Mast Cell Sarcoma	C96.2	Malignant mast cell tumour	CORE ONLY	1
9741/3	Systemic Mastocytosis	C96.2	Malignant mast cell tumour	CORE ONLY	1
9742/3	Mast Cell Leukaemia	C94.3	Mast cell leukaemia	CORE ONLY	1
9751/3 A	Multifocal and multisystemic (disseminated) Langerhans-cell histiocytosis [Letterer-Siwe disease]	C96.0	Multifocal and multisystemic (disseminated) Langerhans-cell histiocytosis [Letterer-Siwe disease]	CORE ONLY	12
9751/3 B	Multifocal and unisystemic (disseminated) Langerhans-cell histiocytosis	C96.5	Multifocal and unisystemic Langerhans-cell histiocytosis	CORE ONLY	12
9751/3 C	Unifocal Langerhans-cell histiocytosis	C96.6	Unifocal Langerhans-cell histiocytosis	CORE ONLY	12
9755/3	Histiocytic sarcoma	C96.8	Histiocytic sarcoma	CORE ONLY	12
9756/3	Langerhans cell sarcoma	C96.4	Sarcoma of dendritic cells (accessory cells)	CORE ONLY	12
9757/3	Interdigitating dendritic cell sarcoma	C96.4	Sarcoma of dendritic cells (accessory cells)	CORE ONLY	12
9757/3 A	Dendritic cell tumour, NOS	C96.4	Sarcoma of dendritic cells (accessory cells)	CORE ONLY	12
9758/3	Follicular dendritic cell sarcoma	C96.4	Sarcoma of dendritic cells (accessory cells)	CORE ONLY	12
9759/3	Fibroblastic reticular cell tumour	C96.4	Sarcoma of dendritic cells (accessory cells)	CORE ONLY	12
9760/3	Immunoproliferative disease, NOS	C88.9	Malignant immunoproliferative disease, unspecified	CORE ONLY	9
9761/3	Waldenström macroglobulinaemia This should not have its own title as is not a separate lymphoid disease but a subgroup of LPL.	C88.0	Waldenström macroglobulinaemia	Other Lymphomas	9 WM is a subtype of LPL. Inote they have the same ICD-O-3 code but different ICD10 codes
9762/3	Heavy chain disease	C88.2	Other heavy chain disease	CORE ONLY	9
9762/3 A	Alpha heavy chain disease	C88.3	Immunoproliferative small intestinal disease	CORE ONLY	9
9762/3 B	Gamma heavy chain disease	C88.2	Other heavy chain disease	CORE ONLY	9
9762/3 C	Mu heavy chain disease	C88.2	Other heavy chain disease	CORE ONLY	9
9764/3	Immunoproliferative small intestinal disease	C88.3	Immunoproliferative small intestinal disease	Other Lymphomas	9

ICD-O-3	ICD-O-3 WHO Description	ICD-10 (4th Edition)	ICD10 Description	Clinical dataset	WHO DISEASE GROUP
9766/1	Lymphomatoid granulomatosis	D47.7	Other specified neoplasms of uncertain or unknown behaviour of lymphoid, haematopoetic and related tissue	CORE ONLY	9
9769/1	Primary Amyloidosis	E85.9	Amyloidosis, unspecified	CORE ONLY	9
9800/3	Leukaemia, NOS	C95.9	Leukaemia, unspecified	CORE ONLY	
9801/3	Acute undifferentiated leukaemia	C95.0	Acute leukaemia of unspecified cell type	AML	6
9805/3	Mixed phenotype acute leukaemia NOS	C95.0	Acute leukaemia of unspecified cell type	AML	6
9806/3	Mixed phenotype acute leukaemia with t(9;22)(q34;q11.2) BCR-ABL1	C95.0	Acute leukaemia of unspecified cell type	AML	6
9807/3	Mixed phenotype acute leukaemia with t(v;11q23) MLL re-arranged	C95.0	Acute leukaemia of unspecified cell type	AML	6
9808/3	Mixed phenotype acute leukaemia, B/myeloid, NOS	C95.0	Acute leukaemia of unspecified cell type	AML	6
9809/3	Mixed phenotype acute leukaemia, T/myeloid, NOS	C95.0	Acute leukaemia of unspecified cell type	AML	6
9811/3 A	B lymphoblastic lymphoma, NOS	C83.5	Lymphoblastic (diffuse) lymphoma	ALL	7
9811/3 B	B lymphoblastic leukaemia, NOS	C91.0	Acute lymphoblastic leukaemia [ALL]	ALL	7
9812/3 A	B lymphoblastic lymphoma with t(9;22)(q34;q11.2);BCR-ABL1	C83.5	Lymphoblastic (diffuse) lymphoma	ALL	7
9812/3 B	B lymphoblastic leukaemia with t(9;22)(q34;q11.2);BCR-ABL1	C91.0	Acute lymphoblastic leukaemia [ALL]	ALL	7
9813/3 A	B lymphoblastic lymphoma with t(v;11q23);MLL re-arranged	C83.5	Lymphoblastic (diffuse) lymphoma	ALL	7
9813/3 B	B lymphoblastic leukaemia with t(v;11q23);MLL re-arranged	C91.0	Acute lymphoblastic leukaemia [ALL]	ALL	7
9814/3 A	B lymphoblastic lymphoma with t(12;21)p13;q22);ETV6-RUNX1	C83.5	Lymphoblastic (diffuse) lymphoma	ALL	7
9814/3 B	B lymphoblastic leukaemia with t(12;21)p13;q22);ETV6-RUNX1	C91.0	Acute lymphoblastic leukaemia [ALL]	ALL	7
9815/3 A	B lymphoblastic lymphoma with hyperdiploidy	C83.5	Lymphoblastic (diffuse) lymphoma	ALL	7
9815/3 B	B lymphoblastic leukaemia with hyperdiploidy	C91.0	Acute lymphoblastic leukaemia [ALL]	ALL	7
9816/3 A	B lymphoblastic lymphoma with hypodiploidy (hypodiploid ALL)	C83.5	Lymphoblastic (diffuse) lymphoma	ALL	7
9816/3 B	B lymphoblastic leukaemia with hypodiploidy (hypodiploid ALL)	C91.0	Acute lymphoblastic leukaemia [ALL]	ALL	7
9817/3 A	B lymphoblastic lymphoma with t(5;14)(q31;q32);IL3-IGH	C83.5	Lymphoblastic (diffuse) lymphoma	ALL	7
9817/3 B	B lymphoblastic leukaemia with t(5;14)(q31;q32);IL3-IGH	C91.0	Acute lymphoblastic leukaemia [ALL]	ALL	7
9818/3 A	B lymphoblastic lymphoma with t(1;19)(q23;p13.3);TCF3-PBX1	C83.5	Lymphoblastic (diffuse) lymphoma	ALL	7
9818/3 B	B lymphoblastic leukaemia with t(1;19)(q23;p13.3);TCF3-PBX1	C91.0	Acute lymphoblastic leukaemia [ALL]	ALL	7

ICD-O-3	ICD-O-3 WHO Description	ICD-10 (4th Edition)	ICD10 Description	Clinical dataset	WHO DISEASE GROUP
9823/3	Chronic lymphocytic leukaemia/small lymphocytic lymphoma	C91.1	Chronic lymphocytic leukaemia of B-cell type	CLL	9
9826/3	Burkitt cell leukaemia	C91.8	Mature B-cell leukaemia Burkitt-type	ALL	9
9827/3	Adult T-cell leukaemia/lymphoma	C91.5	Adult T-cell lymphoma/leukaemia (HTLV-1-associated)	Other Lymphomas	10
9831/3	T-cell large granular lymphocytic leukaemia	C91.7	Other lymphoid leukaemia	CORE ONLY	10
9831/3 A	Chronic lymphoproliferative disorder of NK-cells	C91.7	Other lymphoid leukaemia	CORE ONLY	10
9833/3	B-cell prolymphocytic leukaemia	C91.3	Prolymphocytic leukaemia of B-cell type	CORE ONLY	9
9834/3	T-cell prolymphocytic leukaemia	C91.6	Prolymphocytic leukaemia of T-cell type	CORE ONLY	10
9837/3	T lymphoblastic leukaemia	C91.0	Acute lymphoblastic leukaemia [ALL]	ALL	8
9840/3	Acute erythroid leukaemia	C94.0	Acute erythroid leukaemia	AML	5
9860/3	Myeloid leukaemia, NOS	C92.9	Myeloid leukaemia, unspecified	CORE ONLY	
9861/3 A	AML with mutated CEBPA	C92.0	Acute myeloblastic leukaemia [AML]	AML	5
9861/3 B	AML with mutated NPM1	C92.0	Acute myeloblastic leukaemia [AML]	AML	5
9861/3 C	Acute myeloid leukaemia, NOS	C92.0	Acute myeloblastic leukaemia [AML]	AML	5
9865/3	AML with t(6;9)(p23;q34) DEK-NUP214	C92.0	Acute myeloblastic leukaemia [AML]	AML	5
9866/3	Acute promyelocytic leukaemia with t(15;17)(q22;q12) PML-RARA	C92.4	Acute promyelocytic leukaemia [PML]	AML	5
9867/3	Acute myelomonocytic leukaemia	C92.5	Acute myelomonocytic leukaemia	AML	5
9869/3	AML with inv(3)(q21q26.2) or t(3;3)(q21;126.2) RPRN1-EVI1	C92.0	Acute myeloblastic leukaemia [AML]	AML	5
9870/3	Acute basophilic leukaemia	C92.7	Other myeloid leukaemia	AML	5
9871/3	AML with inv(16)(p13.1;q22) or t(16;16)(p13.1;q22) CBFB-MYH11	C92.5	Acute myelomonocytic leukaemia	AML	5
9872/3	AML with minimal differentiation	C92.0	Acute myeloblastic leukaemia [AML]	AML	5
9873/3	AML without maturation	C92.0	Acute myeloblastic leukaemia [AML]	AML	5
9874/3	AML with maturation	C92.0	Acute myeloblastic leukaemia [AML]	AML	5
9875/3	Chronic Myelogenous Leukaemia, BCR-ABL1 positive	C92.1	Chronic myeloid leukaemia [CML], BCR/ABL-positive	CML	1
9875/3 A	Chronic Myelogenous Leukaemia, Accelerated Phase	C92.1	Chronic myeloid leukaemia [CML], BCR/ABL-positive	CML	1
9875/3 B	Chronic Myelogenous Leukaemia, Blastic Phase	C92.1	Chronic myeloid leukaemia [CML], BCR/ABL-positive	CML	1

ICD-O-3	ICD-O-3 WHO Description	ICD-10 (4th Edition)	ICD10 Description	Clinical dataset	WHO DISEASE GROUP
9875/3 C	Chronic Myelogenous Leukaemia, Chronic Phase	C92.1	Chronic myeloid leukaemia [CML], BCR/ABL-positive	CML	1
9876/3	Atypical chronic myeloid leukaemia, BCR-ABL1 negative	C92.2	Atypical chronic myeloid leukaemia, BCR/ABL-negative	MDS	1
9891/3	Acute monoblastic and monocytic leukaemia	C93.0	Acute monoblastic/monocytic leukaemia	AML	5
9895/3	AML with myelodysplasia-related changes	C92.8	Acute myeloid leukaemia with multilineage dysplasia	AML	5
9896/3	AML with t(8;21)(q22;q22) RUNX1-RUNX1T1	C92.0	Acute myeloblastic leukaemia [AML]	AML	5
9897/3	AML with t(9;11)(p22;q23) MLLT3-MLL	C92.6	Acute myeloid leukaemia with 11q23-abnormality	AML	5
9898/1	Transient abnormal myelopoiesis	D47.1	Chronic myeloproliferative disease	CORE ONLY	5
9898/3	Myeloid leukaemia associated with Down syndrome	C92.7	Other myeloid leukaemia	AML	5
9910/3	Acute megakaryoblastic leukaemia	C94.2	Acute megakaryoblastic leukaemia	AML	5
9911/3	AML (megakaryoblastic) with t(1;22)(p13;q13) RBM15-MKL1	C94.2	Acute megakaryoblastic leukaemia	AML	5
9920/3	t-AML	C92.0	Acute myeloblastic leukaemia [AML]	AML	5
9920/3 A	t-MDS/MPN	C94.6	Myelodysplastic and myeloproliferative disease, not elsewhere classified	MDS	5
9920/3 B	t-MDS	D46.7	Other myelodysplastic syndromes	MDS	5
9930/3	Myeloid sarcoma	C92.3	Myeloid sarcoma	CORE ONLY	5
9931/3	Acute panmyelosis with myelofibrosis	C94.4	Acute panmyelosis with myelofibrosis	CORE ONLY	5
9940/3	Hairy cell leukaemia	C91.4	Hairy-cell leukaemia	CORE ONLY	9
9945/3	Chronic myelomonocytic leukaemia	C93.1	Chronic myelomonocytic leukaemia	MDS	3
9946/3	Juvenile myelomonocytic leukaemia	C93.3	Juvenile myelomonocytic leukaemia	MDS	3
9948/3	Aggressive NK cell leukaemia	C95.0	Acute leukaemia of unspecified cell type	CORE ONLY	10
9950/3	Polycythaemia vera*	D45	Polycythaemia vera	CORE ONLY	1
9960/3	Chronic myeloproliferative neoplasm, NOS*	D47.1	Chronic myeloproliferative disease	CORE ONLY	1
9961/3	Primary myelofibrosis*	D47.4	Osteomyelofibrosis	CORE ONLY	1
9962/3	Essential Thrombocythaemia*	D47.3	Essential (haemorrhagic) thrombocythaemia	CORE ONLY	1
9963/3	Chronic neutrophilic leukaemia	D47.1	Chronic myeloproliferative disease	CORE ONLY	1
9964/3	Chronic eosinophilic leukaemia, NOS*	D47.5	Chronic eosinophilic leukaemia [hypereosinophilic syndrome]	CORE ONLY	1
9965/3	Myeloid and lymphoid neoplasms with PDGFRA re-arrangement	C92.7	Other myeloid leukaemia	CORE ONLY	2

ICD-O-3	ICD-O-3 WHO Description	ICD-10 (4th Edition)	ICD10 Description	Clinical dataset	WHO DISEASE GROUP
9966/3	Myeloid neoplasms with PDGFRB	C92.7	Other myeloid leukaemia	CORE ONLY	2
9967/3	Myeloid and lymphoid neoplasms with FGFR1 abnormalities	C92.7	Other myeloid leukaemia	CORE ONLY	2
9971/1 A	Early lesions plasmacytic hyperplasia	D47.9	Neoplasm of uncertain or unknown behaviour of lymphoid, haematopoietic and related tissue, unspecified	CORE ONLY	13
9971/1 B	Early lesions infectious mononucleosis-like PTLD	D47.9	Neoplasm of uncertain or unknown behaviour of lymphoid, haematopoietic and related tissue, unspecified	CORE ONLY	13
9971/3 A	Polymorphic PTLD*	D47.9	Neoplasm of uncertain or unknown behaviour of lymphoid, haematopoietic and related tissue, unspecified	CORE ONLY	13
9971/3 B	Monomorphic PTLD (B- and T/NK-cell types)*	D47.9	Neoplasm of uncertain or unknown behaviour of lymphoid, haematopoietic and related tissue, unspecified	CORE ONLY	13
9971/3 C	Classical Hodgkin lymphoma type PTLD*	C81.9	Hodgkin lymphoma, unspecified	CORE ONLY	13
9975/3	Myeloproliferative neoplasm, unclassifiable*	D47.1	Chronic myeloproliferative disease	CORE ONLY	1
9975/3 A	Myelodysplastic/Myeloproliferative neoplasm, unclassifiable	C94.6	Myelodysplastic and myeloproliferative disease, not elsewhere classified	CORE ONLY	3
9980/3	Refractory anaemia*	D46.4	Refractory anaemia, unspecified	MDS	4
9982/3 A	Refractory anaemia with ring sideroblasts*	D46.1	Refractory anaemia with ringed sideroblasts	MDS	4
9982/3 B	Refractory anaemia with ring sideroblasts associated with marked thrombocytosis*	D46.1	Refractory anaemia with ringed sideroblasts	MDS	4
9983/3	Refractory anaemia with excess blasts*	D46.2	Refractory anaemia with excess of blasts	MDS	4
9985/3	Refractory cytopenia with multilineage dysplasia*	D46.5	Refractory anaemia with multi-lineage dysplasia	MDS	4
9985/3 A	Refractory cytopenia of childhood*	D46.5	Refractory anaemia with multi-lineage dysplasia	MDS	4
9986/3	Myelodysplastic syndrome associated with isolated del(5q)*	D46.6	Myelodysplastic syndrome with isolated del(5q) chromosomal abnormality	MDS	4
9989/3	Myelodysplastic syndrome, unclassifiable*	D46.9	Myelodysplastic syndrome, unspecified	MDS	4
9991/3	Refractory neutropenia*	D46.7	Other Myelodysplastic syndromes	MDS	4
9992/3	Refractory thrombocytopenia*	D46.7	Other Myelodysplastic syndromes	MDS	4
		C81.7	Other classical Hodgkin lymphoma	Redundant (reclassified)**	
		C82.5	Diffuse follicle centre lymphoma	Redundant (reclassified)**	
		C82.7	Other types of follicular lymphoma	Redundant (reclassified)**	
		C83.9	Non-follicular (diffuse) lymphoma, unspecified	Redundant (reclassified)**	

ICD-O-3	ICD-O-3 WHO Description	ICD-10 (4th Edition)	ICD10 Description	Clinical dataset	WHO DISEASE GROUP
		C88.7	Other malignant immunoproliferative diseases	Redundant (reclassified)**	
		C93.7	Other monocytic leukaemia	Redundant (reclassified)**	
		C93.9	Monocytic leukaemia, unspecified	Redundant (reclassified)**	
		C94.7	Other specified leukaemias	Redundant (reclassified)**	
		C95.1	Chronic leukaemia of unspecified cell type	Redundant (reclassified)**	
		C95.7	Other leukaemia of unspecified cell type	Redundant (reclassified)**	
		C96.7	Other specified malignant neoplasms of lymphoid, haematopoietic and related tissue	Redundant (reclassified)**	
		C96.9	Malignant neoplasms of lymphoid, haematopoietic and related tissue, unspecified	Redundant (reclassified)**	
	not used in ICD-O-3 (D46.4 used instead)	D46.0	Refractory anaemia without ringed sideroblasts, so stated	Redundant (reclassified)**	
		D47.9	Neoplasm of uncertain or unknown behaviour of lymphoid, haematopoietic and related tissue, unspecified	Redundant (reclassified)**	

*** There is a behaviour discrepancy between the ICD10 site code and the new ICD-O-3 morphology code - although these diseases are now coded with a behaviour code of 3 they are still recorded with a D code in ICD10**

**** Redundant - disease has been reclassified under other codes**

7.3 HAEMATOLOGY – CLINICAL DATASETS AND APPLICABLE DATA ITEMS

The following table shows which of the site specific data items are applicable to each clinical dataset.

Note: There are also some core data items which are used to calculate some of the indices, e.g. Age, gender, performance status)

Clinical Dataset		DATA ITEM #	SITE SPECIFIC DATA ITEM
AML	WBC	HA8150	WHITE BLOOD CELL COUNT (HIGHEST PRE TREATMENT)
	Cytogenetics group	HA8160	CYTOGENETIC GROUP (ACUTE MYELOID LEUKAEMIA)
ALL	WBC	HA8150	WHITE BLOOD CELL COUNT (HIGHEST PRE TREATMENT)
	Extramedullary disease	HA8270	EXTRAMEDULLARY DISEASE
CML	Spleen	HA8000	SPLEEN CM BELOW COSTAL MARGIN
	Platelets	HA8030	PLATELET COUNT
	Blood Myeloblasts	HA8040	BLOOD MYELOBLASTS
	Blood Basophils	HA8050	BLOOD BASOPHILS PERCENTAGE
	Blood Eosinophils	HA8060	BLOOD EOSINOPHILS PERCENTAGE
	Hasford score	HA8010	SOKAL INDEX (CHRONIC MYELOID LEUKAEMIA)
	Sokol score	HA8020	HASFORD INDEX (CHRONIC MYELOID LEUKAEMIA)
CLL	Hepatomegaly	HA8200	HEPATOMEGALY INDICATOR
	Splenomegaly	HA8210	SPLENOMEGALY INDICATOR
	Lymphadenopathy	HA8220	NUMBER OF LYMPHADENOPATHY AREAS
	Hb	HA8100	BLOOD HAEMOGLOBIN CONCENTRATION
	Platelets	HA8030	PLATELET COUNT
	Binet	HA8240	BINET STAGE
	Rai	HA8230	RAI STAGE
Myelodysplasia (MDS)	Hb	HA8100	BLOOD HAEMOGLOBIN CONCENTRATION
	Platelets	HA8030	PLATELET COUNT
	Neutrophils	HA8130	NEUTROPHIL COUNT
	Marrow blasts	HA8120	BONE MARROW BLASTS PERCENTAGE
	Karyotype	HA8110	BONE MARROW KARYOTYPE
	IPSS index	HA8080	IPSS (MYELODYSPLASIA)
Myeloma	Albumin	HA8550	ALBUMIN LEVEL
	Beta 2 microglobulin	HA8540	BETA2 MICROGLOBULIN LEVEL
	ISS Stage	HA8560	ISS STAGE for MYELOMA
Follicular	Ann Arbor stage	HA8280	ANN ARBOR STAGE
	Ann Arbor symptoms	HA8290	ANN ARBOR SYMPTOMS
	Ann Arbor extranodality	HA8300	ANN ARBOR EXTRANODALITY
	Ann Arbor Bulk	HA8310	ANN ARBOR BULK
	Nodal areas	HA8320	NUMBER OF ABNORMAL NODAL AREAS
	Primary Extranodal Site	HA8330	PRIMARY EXTRANODAL SITE
	Hb	HA8100	BLOOD HAEMOGLOBIN CONCENTRATION
	LDH	HA8350	LACTATE DEHYDROGENASE LEVEL
	FLIPI	HA8360	FLIPI INDEX SCORE

Clinical Dataset		DATA ITEM #	SITE SPECIFIC DATA ITEM
DLBCL	Ann Arbor stage	HA8280	ANN ARBOR STAGE
	Ann Arbor symptoms	HA8290	ANN ARBOR SYMPTOMS
	Ann Arbor extranodality	HA8300	ANN ARBOR EXTRANODALITY
	Ann Arbor Bulk	HA8310	ANN ARBOR BULK
	Extranodal sites	HA8420	NUMBER OF EXTRANODAL SITES CODE
	Primary Extranodal Site	HA8330	PRIMARY EXTRANODAL SITE
	LDH	HA8350	LACTATE DEHYDROGENASE LEVEL
	(R)IPI	HA8450	(R)IPI INDEX for DLBCL SCORE
Other Lymphomas	Ann Arbor stage	HA8280	ANN ARBOR STAGE
	Ann Arbor symptoms	HA8290	ANN ARBOR SYMPTOMS
	Ann Arbor extranodality	HA8300	ANN ARBOR EXTRANODALITY
	Ann Arbor Bulk	HA8310	ANN ARBOR BULK
	Primary Extranodal Site	HA8330	PRIMARY EXTRANODAL SITE
	LDH	HA8350	LACTATE DEHYDROGENASE LEVEL
Hodgkin	Ann Arbor stage	HA8280	ANN ARBOR STAGE
	Ann Arbor symptoms	HA8290	ANN ARBOR SYMPTOMS
	Ann Arbor extranodality	HA8300	ANN ARBOR EXTRANODALITY
	Ann Arbor Bulk	HA8310	ANN ARBOR BULK
	Primary Extranodal Site	HA8330	PRIMARY EXTRANODAL SITE
	Hb	HA8100	BLOOD HAEMOGLOBIN CONCENTRATION
	Albumin	HA8550	ALBUMIN LEVEL
	WBC	HA8150	WHITE BLOOD CELL COUNT (HIGHEST PRE TREATMENT)
	Lymphocytes	HA8660	BLOOD LYMPHOCTYE COUNT
	Hasenclever index	HA8670	HASENCLEVER INDEX

7.4 HAEMATOLOGY – LABORATORY RESULTS – VARIOUS

To carry laboratory results, for various haematological diseases, as specified.

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
HA8030	HAEMATOLOGY - LABORATORY RESULTS - CML, CLL, MYELODYSPLASIA	**PLATELET COUNT** *[PLATELETS COUNT]*	max n4	R
HA8150	HAEMATOLOGY - LABORATORY RESULTS - AML, ALL, HODGKIN	**WHITE BLOOD CELL COUNT** *(HIGHEST PRETREATMENT)*	max n3.n1	R
HA8100	HAEMATOLOGY - LABORATORY RESULTS - CLL, MYELODYSPLASIA, HODGKIN, FOLLICULAR	**BLOOD HAEMOGLOBIN CONCENTRATION (GRAMS PER LITRE)** *[HAEMOGLOBIN CONCENTRATION (GRAMS PER LITRE)]*	max n3	R

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
HA8110	HAEMATOLOGY - - LABORATORY RESULTS - MYELODYSPLASIA	**BONE MARROW KARYOTYPE** *[KARYOTYPE TEST OUTCOME]*	an1	R
HA8120	HAEMATOLOGY - LABORATORY RESULTS -MYELODYSPLASIA -	**BONE MARROW BLASTS PERCENTAGE** *[BONE MARROW BLAST CELLS PERCENTAGE]*	max n2	R
HA8130	HAEMATOLOGY - LABORATORY RESULTS - MYELODYSPLASIA	**NEUTROPHIL COUNT**	max n3.n1	R
HA8550	HAEMATOLOGY - LABORATORY RESULTS - MYELOMA, HODGKIN	**ALBUMIN LEVEL**	n2	R
HA8540	HAEMATOLOGY - LABORATORY RESULTS -MYELOMA	**BETA2 MICROGLOBULIN LEVEL**	max n2.n1	R
HA8660	HAEMATOLOGY LABORATORY RESULTS - - HODGKIN	**BLOOD LYMPHOCYTE COUNT**	max n2.n1	R
HA8350	HAEMATOLOGY - LABORATORY RESULTS - FOLLICULAR, DLBCL, OTHER LYMPHOMAS	**LACTATE DEHYDROGENASE LEVEL**	an1	R
HA8040	HAEMATOLOGY - LABORATORY RESULTS -CML	**BLOOD MYELOBLASTS PERCENTAGE**	max n3	R
HA8050	HAEMATOLOGY - LABORATORY RESULTS - CML	**BLOOD BASOPHILS PERCENTAGE**	max n3	R
HA8060	HAEMATOLOGY - LABORATORY RESULTS - CML	**BLOOD EOSINOPHILS PERCENTAGE**	max n3	R
HA8160	HAEMATOLOGY - LABORATORY RESULTS - AML	**CYTOGENETIC GROUP (ACUTE MYELOID LEUKAEMIA)** *[CYTOGENETIC RISK CODE (ACUTE MYELOID LEUKAEMIA HAEMATOLOGY)]*	an1	R

PLATELET COUNT: Level of platelets in blood as n x 10^9 per litre, to be collected at diagnosis. Normally provided by Haematology lab before transfusion/treatment.

Range: 0 – 5000

WHITE BLOOD CELL COUNT (HIGHEST PRETREATMENT): Highest White blood cell count pre-treatment (x 10^9 per litre). Normally provided by Haematology lab before transfusion/treatment.

Range 0.0 to 999.9 (to 1dp)

BLOOD HAEMOGLOBIN CONCENTRATION (GRAMS PER LITRE): Blood haemoglobin concentration g/l.

Normally provided by Haematology lab before transfusion/treatment.

BONE MARROW KARYOTYPE: Karyotype of marrow sample as classified by MDT from laboratory result of sample taken pre-treatment. From Cytogenetics laboratory (maybe as part of integrated haematopathology report). Classification/coding may be done by the lab or the MDT.

Classify as:

- Good - if normal.-Y, del (5q), del (20q)

- Intermediate - if any other abnormalities
- Poor - if complex (more than 2 abnormalities) or chromosome7 abnormalities

G	Good
I	Intermediate
P	Poor
N	No result

BONE MARROW BLASTS PERCENTAGE: Blast cells in bone marrow aspirate as percentage of all nucleated cells. Normally taken from laboratory report on diagnostic bone marrow.

(%) Range 0 – 20

NEUTROPHIL COUNT: Blood neutrophil count n/dl. Normally provided by Haematology lab before transfusion/treatment.

Range 0.0 to 999.9 (to 1dp)

Range 10 to 80

ALBUMIN LEVEL: Level in serum of albumin as g per litre measured pre-treatment. Normally provided from Biochemistry laboratory before treatment.

BETA2 MICROGLOBULIN LEVEL: Level in serum of beta 2 microglobulin as mg per litre measured pre-treatment. Normally provided from Biochemistry laboratory before treatment.

Range 0.0 to 99.9 (to 1dp)

BLOOD LYMPHOCYTE COUNT: Number of lymphocytes in blood measured pre-treatment. Normally provided by Haematology lab before transfusion/treatment.

Range 0.0 to 99.9 (to 1dp)

LACTATE DEHYDROGENASE LEVEL: Lactate Dehydrogenase level in serum measured pre-treatment. Normally provided from Biochemistry laboratory before treatment.

A	Above normal
B	Not above normal
9	Test not done

BLOOD MYELOBLASTS PERCENTAGE: Myeloblasts as percentage of total white cells. Normally provided by Haematology lab before transfusion/treatment.

(% Range) 0-100

BLOOD BASOPHILS PERCENTAGE: Basophils as percentage of total white cells. Normally provided by Haematology lab before transfusion/treatment.

(% Range) 0 – 100

BLOOD EOSINOPHILS PERCENTAGE: Eosinophils as percentage of total white cells. Normally provided by Haematology lab before transfusion/treatment.

(% Range) 0 – 100

CYTOGENETIC GROUP (ACUTE MYELOID LEUKAEMIA): Cytogenetic analysis of bone marrow (preferably) or blood sample. From Cytogenetics laboratory (maybe as part of integrated haematopathology report). Classification/coding may be done by the lab or the MDT.

Classify as:

- Favourable - if t(8;21), t(15;17), inv(16) irrespective of other abnormalities;
- Adverse - if monosomy 5, monosomy 7, del (5q), abnormality of 3q, more than 4 abnormalities;
- Intermediate - if any other abnormality, or normal karyotype.

F	Favourable
A	Adverse
I	Intermediate
N	No result

Note: "No Result" includes "Test not done"

7.5 HAEMATOLOGY – CANCER CARE PLAN – VARIOUS

To carry cancer care plan details, specifically Nodal details, for various haematological diseases, as specified.

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
HA8320	HAEMATOLOGY - FOLLICULAR	**NUMBER OF ABNORMAL NODAL AREAS**	max n2	R
HA8330	HAEMATOLOGY - CANCER CARE PLAN - FOLLICULAR, DLBCL, OTHER LYMPHOMAS, HODGKIN	**PRIMARY EXTRANODAL SITE**	an2	R
HA8420	HAEMATOLOGY - CANCER CARE PLAN - DLBCL	**NUMBER OF EXTRANODAL SITES CODE**	an1	R

NUMBER OF ABNORMAL NODAL AREAS: Number of abnormal nodal areas detected clinically and radiologically.

PRIMARY EXTRANODAL SITE: Site of origin of lymphoma if believed to be outside lymph nodes as agreed by MDT based on clinical and radiological findings.

01	Blood
02	Bone
03	CNS
04	GIT
05	GU
06	Liver
07	Marrow
08	Muscle
09	Orbit
10	Pericardium

11	Pulmonary
12	Salivary gland
13	Skin
14	Thyroid
15	Other

NUMBER OF EXTRANODAL SITES CODE: Number of sites with Lymphoma outside lymph nodes (clinical assessment).

0	0
1	1
2	More than 1

7.6 HAEMATOLOGY – CANCER CARE PLAN – CHRONIC MYELOID LEUKAEMIA

To carry cancer care plan details specific to Chronic Myeloid Leukaemia (CML).

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
HA8000	HAEMATOLOGY - CANCER CARE PLAN - CML	**SPLEEN CM BELOW COSTAL MARGIN**	max n2	R
HA8010	HAEMATOLOGY - CANCER CARE PLAN - CML	**SOKAL INDEX (CHRONIC MYELOID LEUKAEMIA)** *[CHRONIC MYELOID LEUKAEMIA INDEX SCORE (SOKAL)]*	n1.n1	R
HA8020	HAEMATOLOGY - CANCER CARE PLAN - CML	**HASFORD INDEX (CHRONIC MYELOID LEUKAEMIA)** *[CHRONIC MYELOID LEUKAEMIA INDEX SCORE (HASFORD)]*	an1	R

SPLEEN CM BELOW COSTAL MARGIN: Maximum distance from the costal margin in centimetres. Measured (not estimated) by person examining patient.

Range 0 - 50 (cm)

SOKAL INDEX (CHRONIC MYELOID LEUKAEMIA): Index derived from age, spleen size, platelet count, myeloblasts %.

$$e^{\left(0.0116(Age\,[in\,years]-43.4)+0.0345(Spleen\,[size\,in\,cm\,below\,costal\,region]-7.51)+0.188\left(\left(\frac{Platelets\,[*10^9/L]}{700}\right)^2-0.563\right)+0.0877(blasts\,[\%]-2.1)\right)}$$

HASFORD INDEX (CHRONIC MYELOID LEUKAEMIA): Index derived from age, spleen size, platelet count, myeloblasts %, eosinophils %, basophils %.

L	Low (= less than 781)
I	Intermediate (= 781 - 1480)
H	High (= >1480)

$$\text{Score} = \left(\left(0.6666 * \text{age} \begin{Bmatrix} 0 \, if < 50 \, years \\ 1 \, if \geq 50 \, years \end{Bmatrix} \right) + (0.0420 * spleen\ size\ \{cm\ below\ costal\ region\}) + (0.0584 * blasts\ \{\%\}) \right.$$

$$\left. + (0.0413 * eosinophils\ \{\%\}) + \left(0.2039 * basophils \begin{Bmatrix} 0 \, if < 3\% \\ 1 \, if \geq 3\% \end{Bmatrix} \right) + \left(1.0956 * platelets \begin{Bmatrix} 0 \, if < 1500 * 10^9 / L \\ 1 \, if \geq 1500 * 10^9 / L \end{Bmatrix} \right) \right) * 1000$$

7.7 HAEMATOLOGY – CANCER CARE PLAN – MYELODYSPLASIA

To carry cancer care plan details specific to Myelodysplasia.

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
HA8080	HAEMATOLOGY - CANCER CARE PLAN - MYELODYSPLASIA	**IPSS (MYELODYSPLASIA)** *[INTERNATIONAL PROGNOSTIC SCORING SYSTEM SCORE]*	n1.n1	M

IPSS (MYELODYSPLASIA): INTERNATIONAL PROGNOSTIC SCORING SYSTEM for myelodysplasia. Index derived from BM blasts %, Karyotype, Platelet count, Hb, Neutrophils

- Score 0 for BM Blasts % less than 5, 0.5 for 5-10, 1.5 for 11-20.
- Score 0 for Karyotype Good, 0.5 for Intermediate, 1 for Poor.
- Score 0 for 0/1 cytopenias, 0.5 for 2/3 cytopenias.
- (Cytopenia Yes if Platelet count less than 100 and Haemoglobin less than 100 and Neutrophils less than 1.8)
- Score range 0 to 3.0

The use of IPSS will be reviewed in light of the recently published IPSS- R scoring system. IPSS as described above will be retained until any changes are agreed.

7.8 HAEMATOLOGY – CANCER CARE PLAN – CHRONIC LYMPHOCYTIC LEUKAEMIA

To carry cancer care plan details specific to Applicable to Chronic Lymphocytic Leukaemia.

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
HA8200	HAEMATOLOGY - CANCER CARE PLAN - CLL	**HEPATOMEGALY INDICATOR**	an1	R
HA8210	HAEMATOLOGY -- CANCER CARE PLAN - CLL	**SPLENOMEGALY INDICATOR**	an1	R
HA8220	HAEMATOLOGY -- CANCER CARE PLAN - CLL	**NUMBER OF LYMPHADENOPATHY AREAS**	n1	R
HA8230	HAEMATOLOGY -- CANCER CARE PLAN - CLL	**RAI STAGE**	an1	R
HA8240	HAEMATOLOGY -- CANCER CARE PLAN - CLL	**BINET STAGE**	an1	R

HEPATOMEGALY INDICATOR: Liver enlargement identified from clinical examination.

Y	Yes
N	No

SPLENOMEGALY INDICATOR: Spleen enlargement identified from clinical examination.

Y	Yes
N	No

NUMBER OF LYMPHADENOPATHY AREAS: Number of enlarged lymph node areas (neck, axilla, groins) identified from clinical assessment.

Range 0-3

RAI STAGE: Applicable to Chronic Lymphocytic Leukaemia.

Prognostic index derived from platelet count, Hb, lymphadenopathy, hepatomegaly, splenomegaly. Note that immune cytopenias are not included when calculating the Stage (ie if Platelet count is below 100 and/or Haemoglobin levels are below 110 as a result of immune cytopenia). Also please see note on calculations below.*

(Rai Stage and Binet Stage "both solely rely on physical examination and standard laboratory tests, and do not require ultrasound, computed tomography, or magnetic resonance imaging. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2972576/?tool=pubmed)

0	Stage 0 if Platelet count> 99 and Hb>109 and no lymphadenopathy, hepatomegaly or splenomegaly
1	Stage I if Platelet count> 99 and Hb>109 and any lymphadenopathy
2	Stage II if hepatomegaly or splenomegaly
3	Stage III if Hb<110

4	Stage IV if platelet count <100

BINET STAGE: Applicable to Chronic Lymphocytic Leukaemia

Prognostic index derived from platelet count, Hb, lymphadenopathy, hepatomegaly, splenomegaly. Note that immune cytopenias are not included when calculating the Stage (ie if Platelet count is below 100 and/or Haemoglobin levels are below 110 as a result of immune cytopenia). Also please see note on calculations below.*

(Rai Stage and Binet Stage "both solely rely on physical examination and standard laboratory tests, and do not require ultrasound, computed tomography, or magnetic resonance imaging." http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2972576/?tool=pubmed)

A	Stage A: if Platelet count > 99 and Hb >99 and 0, 1or 2 areas of organ enlargement (number of lymph node groups plus score 1 for hepatomegaly, 1 for splenomegaly)
B	Stage B: if Platelet count> 99 and Hb>99 and 3, 4 or 5 areas of organ enlargement
C	Stage C: if Hb<100 or platelet count <100

***Notes on Rai Stage and Binet Stage calculations**: "Platelet count >99" is more fully described as "Platelet count > 99 x 10^9/L"

"Hb >109" is more fully described as "Hb >109g/L"

7.9 HAEMATOLOGY – CANCER CARE PLAN – FOLLICULAR LYMPHOMA

To carry cancer care plan details specific to Follicula Lymphoma.

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
HA8360	HAEMATOLOGY - CANCER CARE PLAN - FOLLICULAR	**FLIPI INDEX SCORE** *[FOLLICULAR LYMPHOMA INTERNATIONAL PROGNOSTIC INDEX SCORE]*	n1	M

FLIPI INDEX SCORE: Follicular Lymphoma International Prognostic Index Score (FLIPI), derived from age, Hb, number of nodal areas, LDH, Ann Arbor stage.

Score 1 for age >60 years, Hb < 120 g/l, more than 4 nodal areas, LDH above normal, Stage III or IV.

Range 0 - 5

7.10 HAEMATOLOGY – CANCER CARE PLAN – DIFFUSE LARGE B CELL LYMPHOMA

To carry cancer care plan details specific to DLBCL.

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)

HA8450	HAEMATOLOGY - CANCER CARE PLAN - DLBCL	**(R)IPI INDEX for DLBCL SCORE** *[REVISED INTERNATIONAL PROGNOSTIC INDEX SCORE]*	n1	M

(R)IPI INDEX for DLBCL SCORE: Revised International Prognostic Index Score, derived from Age, performance status, LDH, extranodal sites, Ann Arbor Stage.

Score 1 for each of age >60, PS ≥ 2, LDH above Normal, >1 extranodal site, stage III or IV.

Range 0 – 5

Either (R)IPI or IPI may currently be used as prognostic indicators. However the scores calculated as above apply to both indices and can be grouped to provide either the IPI or the (R)IPI Groupings.

7.11 HAEMATOLOGY – CANCER CARE PLAN – MYELOMA

To carry cancer care plan details specific to Myeloma.

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
HA8560	HAEMATOLOGY - CANCER CARE PLAN - MYELOMA	**ISS STAGE for MYELOMA** *[INTERNATIONAL STAGING SYSTEM STAGE]*	an1	M

ISS STAGE for MYELOMA: International Staging System for Myeloma derived from Beta2 Microglobulin and Albumin lab results.

1	Stage 1: Beta 2 M less than 3.5 and Albumin greater than 34
2	Stage 2: Beta 2 M less than 3.5 and albumin less than 35, OR Beta 2 M 3.5 - 5.5
3	Stage 3: Beta 2 M greater than 5.5

7.12 HAEMATOLOGY – CANCER CARE PLAN – HODGKIN LYMPHOMA

To carry cancer care plan details specific to Hodgkin.

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
HA8670	HAEMATOLOGY - CANCER CARE PLAN - HODGKIN	**HASENCLEVER INDEX** *[HASENCLEVER INDEX SCORE]*	n1	M

HASENCLEVER INDEX: Index derived from age, gender, Hb, Albumin, white blood count, Lymphocyte count, Ann Arbor stage. (Score 1 for each of Age >44, Male gender, Hb<105, Albumin <40, White blood count >14.9, Lymphocyte count<0.6 (or Lymphocyte percentage of white blood cells <8%), Ann Arbor Stage IV)

Note: Hasenclever Index is only required for lymphomas with Ann Arbor Stage 3 or 4.

Range 0-7

7.13 HAEMATOLOGY – CANCER CARE PLAN – ACUTE LYMPHOCYTIC LEUKAEMIA

To carry cancer care plan details specific to Acute Lymphocytic Leukaemia's.

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
HA8270	HAEMATOLOGY - CANCER CARE PLAN - Acute Lymphocytic Leukaemia -	**EXTRAMEDULLARY DISEASE** *[EXTRAMEDULLARY DISEASE SITE]*	an1	R

EXTRAMEDULLARY DISEASE [EXTRAMEDULLARY DISEASE SITE]: Sites of disease identified outside bone marrow.

T	Testes
C	CNS
O	Other

7.14 HAEMATOLOGY – STAGING – HODGKIN, FOLLICULAR, DLBCL, OTHER LYMPHOMAS

To carry staging details, specifically Ann Arbor staging details, for various haematological diseases, as specified.

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
HA8280	HAEMATOLOGY - STAGING - FOLLICULAR, DLBCL OTHER LYMPHOMAS, HODGKIN	**ANN ARBOR STAGE**	an1	M
HA8290	HAEMATOLOGY - STAGING - FOLLICULAR, DLBCL OTHER LYMPHOMAS, HODGKIN	**ANN ARBOR SYMPTOMS** *[ANN ARBOR SYMPTOMS INDICATOR]*	an1	R
HA8300	HAEMATOLOGY - CANCER CARE PLAN - FOLLICULAR, DLBCL OTHER LYMPHOMAS, HODGKIN	**ANN ARBOR EXTRANODALITY** *[ANN ARBOR EXTRA INDICATOR]*	an1	R
HA8310	HAEMATOLOGY - CANCER CARE PLAN - FOLLICULAR, DLBCL OTHER LYMPHOMAS, HODGKIN	**ANN ARBOR BULK** *[ANN ARBOR BULK INDICATOR]*	an1	R

ANN ARBOR STAGE: Staging based on location of detected disease.

1	I = One region of lymph nodes, or spleen or thymus or Waldeyer's ring enlarged
2	II = 2 regions of lymph nodes enlarged, on same side of diaphragm
3	III = lymph nodes enlarged on both sides of diaphragm
4	IV = disease outside lymph nodes e.g. liver, bone marrow excluding E

ANN ARBOR SYMPTOMS: Additional stage designation based on presence or absence of specific symptoms.

A	No Symptoms
B	Presence of any of the following: unexplained persistent or recurrent fever (greater than 38°C / 101.5°F), drenching night sweats, unexplained weight loss of 10% or more within the last 6 months

ANN ARBOR EXTRANODALITY [ANN ARBOR EXTRANODALITY INDICATOR]: Additional staging designation based on extranodal involvement.

For Primary Nodal lymphoma, code "E" if there is involvement of a single extranodal site by contiguous spread (ie directly adjoining) from the known nodal group.

For Primary Extranodal lymphoma, code “E” if there is a single extranodal lesion with or without lymphatic involvement in the draining area (e.g. a thyroid lymphoma with draining cervical lymph node involvement = “IIE”).

The designation of Stage 4 for nodal disease implies disseminated disease involving (distant) extranodal sites.

Multiple extranodal deposits should be considered Stage IV and “E” should not be used.

However, by convention, involvement of the bone marrow, liver, lung, pleura and CSF are always considered Stage 4 even if the disease is isolated to that organ.

E	E (Extranodal involvement)

ANN ARBOR BULK: Additional staging designation based on presence of bulky disease. Code “X” if there is presence of “bulky” disease, that is, a nodal mass whose greatest dimension is more than 10 centimetres in size, and/or a widening of the mediastinum (middle chest) by more than one-third.

X	X (Yes, “bulky” disease present)

8. HEAD and NECK

OVERVIEW

In the first phase of implementing the COSD, the site specific Head and Neck data items will be collected once pre-treatment and at least once post treatment. The assessment information should be recorded 12 months post diagnosis as a minimum, and annually thereafter, if possible.

ICD-10 CODES

Key:
() = if applicable
* = different dataset from CWT group specified

ICD-10 All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C00.0	External upper lip	Head and Neck		●		
C00.1	External lower lip	Head and Neck		●		
C00.2	External lip, unspecified	Head and Neck		●		
C00.3	Upper lip, inner aspect	Head and Neck	●			
C00.4	Lower lip, inner aspect	Head and Neck	●			
C00.5	Lip, unspecified, inner aspect	Head and Neck	●			
C00.6	Commissure of lip	Head and Neck	●			
C00.8	Overlapping lesion of lip	Head and Neck	●			
C00.9	Lip, unspecified	Head and Neck	●			
C01	Malignant neoplasm of base of tongue	Head and Neck	●			
C02.0	Dorsal surface of tongue	Head and Neck	●			
C02.1	Border of tongue	Head and Neck	●			
C02.2	Ventral surface of tongue	Head and Neck	●			
C02.3	Anterior two-thirds of tongue, part unspecified	Head and Neck	●			
C02.4	Lingual tonsil	Head and Neck	●			
C02.8	Overlapping lesion of tongue	Head and Neck	●			

C02.9	Tongue, unspecified	Head and Neck	●			
C03.0	Upper gum	Head and Neck	●			
C03.1	Lower gum	Head and Neck	●			
C03.9	Gum, unspecified	Head and Neck	●			
C04.0	Anterior floor of mouth	Head and Neck	●			
C04.1	Lateral floor of mouth	Head and Neck	●			
C04.8	Overlapping lesion of floor of mouth	Head and Neck	●			
C04.9	Floor of mouth, unspecified	Head and Neck	●			
C05.0	Hard palate	Head and Neck	●			
C05.1	Soft palate	Head and Neck	●			
C05.2	Uvula	Head and Neck	●			
C05.8	Overlapping lesion of palate	Head and Neck	●			
C05.9	Palate, unspecified	Head and Neck	●			
C06.0	Cheek mucosa	Head and Neck	●			
C06.1	Vestibule of mouth	Head and Neck	●			
C06.2	Retromolar area	Head and Neck	●			
C06.8	Overlapping lesion of other and unspecified parts of mouth	Head and Neck	●			
C06.9	Mouth, unspecified	Head and Neck	●			
C07	Malignant neoplasm of parotid gland	Head and Neck	●			
C08.0	Submandibular gland	Head and Neck	●			
C08.1	Sublingual gland	Head and Neck	●			
C08.8	Overlapping lesion of major salivary glands	Head and Neck	●			
C08.9	Major salivary gland, unspecified	Head and Neck	●			
C09.0	Tonsillar fossa	Head and Neck	●			
C09.1	Tonsillar pillar (anterior) (posterior)	Head and Neck	●			
C09.8	Overlapping lesion of tonsil	Head and Neck	●			
C09.9	Tonsil, unspecified	Head and Neck	●			
C10.0	Vallecula	Head and Neck	●			

C10.1	Anterior surface of epiglottis	Head and Neck	●			
C10.2	Lateral wall of oropharynx	Head and Neck	●			
C10.3	Posterior wall of oropharynx	Head and Neck	●			
C10.4	Branchial cleft	Head and Neck	●			
C10.8	Overlapping lesion of oropharynx	Head and Neck	●			
C10.9	Oropharynx, unspecified	Head and Neck	●			
C11.0	Superior wall of nasopharynx	Head and Neck	●			
C11.1	Posterior wall of nasopharynx	Head and Neck	●			
C11.2	Lateral wall of nasopharynx	Head and Neck	●			
C11.3	Anterior wall of nasopharynx	Head and Neck	●			
C11.8	Overlapping lesion of nasopharynx	Head and Neck	●			
C11.9	Nasopharynx, unspecified	Head and Neck	●			
C12	Malignant neoplasm of pyriform sinus	Head and Neck	●			
C13.0	Postcricoid region	Head and Neck	●			
C13.1	Aryepiglottic fold, hypopharyngeal aspect	Head and Neck	●			
C13.2	Posterior wall of hypopharynx	Head and Neck	●			
C13.8	Overlapping lesion of hypopharynx	Head and Neck	●			
C13.9	Hypopharynx, unspecified	Head and Neck	●			
C14.0	Pharynx, unspecified	Head and Neck	●			
C14.2	Waldeyer's ring	Head and Neck	●			
C14.8	Overlapping lesion of lip, oral cavity and pharynx	Head and Neck	●			
C15.0	*Cervical part of oesophagus*	*Upper Gastrointestinal*	*			*Usually treated by Head & Neck MDT.*
C30.0	Nasal cavity	Head and Neck	●			
C30.1	Middle ear	Head and Neck	●			
C31.0	Maxillary sinus	Head and Neck	●			
C31.1	Ethmoidal sinus	Head and Neck	●			

C31.2	Frontal sinus	Head and Neck	●			
C31.3	Sphenoidal sinus	Head and Neck	●			
C31.8	Overlapping lesion of accessory sinuses	Head and Neck	●			
C31.9	Accessory sinus, unspecified	Head and Neck	●			
C32.0	Glottis	Head and Neck	●			
C32.1	Supraglottis	Head and Neck	●			
C32.2	Subglottis	Head and Neck	●			
C32.3	Laryngeal cartilage	Head and Neck	●			
C32.8	Overlapping lesion of larynx	Head and Neck	●			
C32.9	Larynx, unspecified	Head and Neck	●			
C73	Malignant neoplasm of thyroid gland	Head and Neck		●		
C77.0	Lymph nodes of head, face and neck	Head and Neck	●			Secondary - only use if unable to code to specific primary site
D00.0	Carcinoma in situ of Lip, oral cavity and pharynx	Head and Neck			●	
D02.0	Carcinoma in situ of Larynx	Head and Neck			●	
D09.3	carcinoma in situ of thyroid and other endocrine glands	Head and Neck			●	
D37.0	Neoplasm of uncertain or unknown behaviour of lip, oral cavity and pharynx	Head and Neck			●	
D38.0	Neoplasm of uncertain or unknown behaviour of Larynx	Head and Neck			●	
D44.0	Neoplasm of uncertain or unknown behaviour of thyroid gland	Head and Neck			●	

8.1 HEAD & NECK - PRE TREATMENT ASSESSMENT

To carry pre-treatment assessment details for head and neck cancer.
This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
HN9230 DAHNO D4	HEAD & NECK - PRE TREATMENT ASSESSMENT	**DATE HEIGHT MEASURED** *[OBSERVATION DATE (HEIGHT)]*	an10 ccyy-mm-dd	R
HN9220 DAHNO D3	HEAD & NECK - PRE TREATMENT ASSESSMENT	**PERSON HEIGHT IN METRES**	n1.max n2	R
HN9210 DAHNO D2	HEAD & NECK - PRE TREATMENT ASSESSMENT	**DATE WEIGHT MEASURED** *[OBSERVATION DATE (WEIGHT)]*	an10 ccyy-mm-dd	R
HN9200 DAHNO D1	HEAD & NECK - PRE TREATMENT ASSESSMENT	**PERSON OBSERVATION (WEIGHT)** *[PERSON WEIGHT]*	max n3.max n3	R
HN9060 DAHNO HN22	HEAD & NECK - PRE TREATMENT ASSESSMENT	**CANCER DENTAL ASSESSMENT DATE**	an10 ccyy-mm-dd	R
HN9050 DAHNO HN19	HEAD & NECK - PRE TREATMENT ASSESSMENT	**CARE CONTACT DATE (DIETICIAN INITIAL)**	an10 ccyy-mm-dd	R
HN9140 DAHNO SVR8	HEAD & NECK - PRE TREATMENT ASSESSMENT	**PLANNED POST-OPERATIVE COMMUNICATION METHOD** *[SURGICAL VOICE RESTORATION COMMUNICATION METHOD (PLANNED POST OPERATIVE)]*	an1	R

DATE HEIGHT MEASURED: Date the patient's height was measured.
PERSON HEIGHT IN METRES: Height of the patient, in metres to 2 decimal places (n.nn).
DATE WEIGHT MEASURED: Date the patient's weight was measured.
PERSON OBSERVATION (WEIGHT): Weight of the patient, in kilograms with up to three decimal places (nnn.nnn).
CANCER DENTAL ASSESSMENT DATE: The date of the first dental assessment by a dentally qualified practitioner, which contributes to preparation for treatment. (This is a person who the Multi Disciplinary Team considers suitably qualified to carry out the pre treatment dental assessment of the patient).
CARE CONTACT DATE (DIETICIAN INITIAL): The date that the patient was first assessed by a dietician.
PLANNED POST-OPERATIVE COMMUNICATION METHOD: (Only applicable to head and neck cancer prior to laryngectomy). The patient's proposed method of communication following laryngectomy.

P	PSVR – Primary SVR
S	SSVR – Secondary SVR
E	E – Electrolarynx
O	O – Oesophageal voice
M	M – Mouthing
W	W – Writing or AAC aid
9	9 – Not known

8.3 HEAD & NECK – STAGING

UICC LIP AND ORAL CAVITY ICD 10 C00-C06) TNM STAGING, SEVENTH EDITION

Stage Grouping	*T Stage*	*N Stage*	*M Stage*
Stage I	T1	N0	M0
Stage II	T2	N0	M0
Stage III	T3	N0	M0
	T1,T2,T3	N1	M0
Stage IVA	T4a	N0,N1	M0
	T1,T2,T3,T4a	N2	M0
Stage IVB	Any T	N3	M0
	T4b	Any N	M0
Stage IVC	Any T	Any N	M1

UICC PHARYNX TNM STAGING, SEVENTH EDITION

Stage Grouping	*T Stage*	*N Stage*	*M Stage*
Stage I	T1	N0	M0
Stage II	T2	N0	M0
Stage III	T3	N0	M0
	T1,T2,T3	N1	M0
Stage IVA	T1,T2,T3	N2	M0
	T4a	N0, N1,N2	M0
Stage IVB	T4b	Any N	M0
	Any T	N3	M0
Stage IVC	Any T	Any N	M1

UICC LARYNX TNM STAGING, SEVENTH EDITION

Stage Grouping	*T Stage*	*N Stage*	*M Stage*
Stage I	T1	N0	M0
Stage II	T2	N0	M0
Stage III	T1,T2	N1	M0
	T3	N0, N1	M0
Stage IVA	T4a,T4b	N0, N1	M0
	T1, T2, T3	N2	M0
Stage IVB	T4b	Any N	M0
	Any T	N3	M0
Stage IVC	Any T	Any N	M1

UICC NASAL CAVITY AND PARANASAL SINUSES TNM STAGING, SEVENTH EDITION

Stage Grouping	*T Stage*	*N Stage*	*M Stage*
Stage I	T1	N0	M0
Stage II	T2	N0	M0
Stage III	T3	N0	M0
	T1, T2, T3	N1	M0
Stage IVA	T1, T2, T3	N2	M0
	T4a	N0 ,N1, N2	M0

Stage IVB	T4b	Any N	M0
	Any T	N3	M0
Stage IVC	Any T	Any N	M1

UICC MALIGNANT MELANOMA OF UPPER AERODIGESTIVE TRACT TNM STAGING, SEVENTH EDITION

Stage Grouping	*T Stage*	*N Stage*	*M Stage*
Stage III	T3	N0	M0
Stage IVA	T4a	N0	M0
	T3, T4a	N1	M0
Stage IVB	T4b	Any N	M0
Stage IVC	Any T	Any N	M1

UICC MAJOR SALIVARY GLANDS TNM STAGING, SEVENTH EDITION

Stage Grouping	*T Stage*	*N Stage*	*M Stage*
Stage I	T1	N0	M0
Stage II	T2	N0	M0
Stage III	T3	N0	M0
	T1, T2, T3	N1	M0
Stage IVA	T4a, T4b	N0, N1	M0
	T1, T2, T3, T4a	N2	M0
Stage IVB	T4b	Any N	M0
	Any T	N3	M0
Stage IVC	Any T	Any N	M1

UICC THYROID GLAND (PAPILLARY OR FOLLICULAR) TNM STAGING, SEVENTH EDITION

Stage Grouping	*T Stage*	*N Stage*	*M stage*
under 45 years			
Stage I	Any T	Any N	M0
Stage II	Any T	Any N	M1
45 Years and over			
Stage I	T1a, T1b	N0	M0
Stage II	T2	N0	M0
Stage III	T3	N0	M0
	T1,T2,T3	N1a	M0
Stage IVA	T1,T2,T3	N1b	M0
	T4a	N0,N1	M0
Stage IVB	T4b	Any N	M0
Stage IVC	Any	Any N	M1

UICC THYROID GLAND (MEDULLARY) TNM STAGING, SEVENTH EDITION

Stage Grouping	*T Stage*	*N Stage*	*M Stage*
Stage I	T1a, T1b	N0	M0
Stage II	T2,T3	N0	M0
Stage III	T1, T2, T3	N1a	M0
Stage IVA	T1, T2, T3	N1b	M0
	T4a	Any N	M0
Stage IVB	T4b	Any N	M0

Stage IVC	Any T	Any N	M1

UICC THYROID GLAND (ANAPLASTIC CARCINOMA - ALL ANAPLASTIC CARCINOMA) TNM STAGING, SEVENTH EDITION

Stage Grouping	*T Stage*	*N Stage*	*M Stage*
Stage IVA	T4a	Any N	M0
Stage IVB	T4b	Any N	M0
Stage IVC	Any T	Any N	M1

8.2 HEAD & NECK – POST TREATMENT ASSESSMENT

To carry post treatment assessment details for head and neck cancer.
This section can be recorded more than once. The assessment information should be recorded 12 months post diagnosis as a minimum, and annually thereafter, if possible.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
HN9000 DAHNO 14.1	HEAD & NECK - POST TREATMENT ASSESSMENT	**CLINICAL STATUS ASSESSMENT DATE (CANCER)**	an10 ccyy-mm-dd	M
HN9220 DAHNO D3	HEAD & NECK - POST TREATMENT ASSESSMENT	**PERSON HEIGHT IN METRES**	n1.max n2	R
HN9200 DAHNO D1	HEAD & NECK - POST TREATMENT ASSESSMENT	**PERSON OBSERVATION (WEIGHT)** *[PERSON WEIGHT]*	max n3.max n3	R
HN9010 DAHNO 14.2	HEAD & NECK - POST TREATMENT ASSESSMENT	**PRIMARY TUMOUR STATUS**	an1	R
HN9020 DAHNO 14.3	HEAD & NECK - POST TREATMENT ASSESSMENT	**NODAL STATUS**	an1	R
HN9030 DAHNO 14.4	HEAD & NECK - POST TREATMENT ASSESSMENT	**METASTATIC STATUS**	an1	R
HN9150 DAHNO SVR9	HEAD & NECK - POST TREATMENT ASSESSMENT	**SVR COMMUNICATION PRIMARY METHOD** *[SURGICAL VOICE RESTORATION COMMUNICATION METHOD (PRIMARY)]*	an1	R
HN9080	HEAD & NECK - POST TREATMENT ASSESSMENT	**SPEECH & LANGUAGE ASSESSMENT DATE** *[SPEECH AND LANGUAGE ASSESSMENT DATE]*	an10 ccyy-mm-dd	R

CLINICAL STATUS ASSESSMENT DATE (CANCER): The date on which a clinical assessment was performed.

PERSON HEIGHT IN METRES: Height of the patient, in metres, to 2 decimal places (n.nn).

PERSON OBSERVATION (WEIGHT): Weight of the patient, in kilograms with up to three decimal places (nnn.nnn).

PRIMARY TUMOUR STATUS: The status of the primary tumour at this follow-up contact.

1	Residual primary tumour
2	No evidence of primary tumour
3	Recurrent primary tumour
4	Not assessed
5	Uncertain

NODAL STATUS: The status of the regional nodal metastases at this follow-up contact.

1	Residual regional nodal metastases
2	No evidence of regional nodal metastases
3	New regional nodal metastases
4	Not assessed
5	Uncertain

METASTATIC STATUS: The status of the distant metastases at this follow-up contact.

1	Residual distant metastases
2	No evidence of metastases
3	New distant metastases
4	Not assessed
5	Uncertain

SVR COMMUNICATION PRIMARY METHOD: (Only applicable to head and neck cancer following laryngectomy). The patient's primary method of communication at post-operative contact.

P	VP – Voice prosthesis professionally changed.
S	VS – Voice prosthesis self changed.
E	E – Electrolarynx
O	O – Oesophageal voice
M	M – Mouthing
W	W – Writing or AAC aid

SPEECH & LANGUAGE ASSESSMENT DATE: Record the date of contact where assessment swallowing occurs following completion of treatment. Whilst ideally data is entered at each contact after completion of treatment, key point of recording is at 6 months post cancer care plan agreed date. (Please note this is not the same data item as First SALT Contact Date which is included in the DAHNO dataset from November 2012).

8.3 HEAD & NECK – PATHOLOGY – GENERAL

To carry general pathology details for head and neck cancer.

This section can be recorded more than once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
HN9440	HEAD & NECK - PATHOLOGY -	**INVESTIGATION RESULT**	an10 ccyy-	M

	GENERAL	**DATE**	mm-dd	
HN9450	HEAD & NECK - PATHOLOGY - GENERAL	**SERVICE REPORT IDENTIFIER**	max an18	R

INVESTIGATION RESULT DATE: The date on which an investigation was concluded e.g. the date the result was authorised.
SERVICE REPORT IDENTIFIER: A unique identifier of a SERVICE REPORT.

8.4 HEAD & NECK – PATHOLOGY – VARIOUS

To carry pathology details for various head and neck cancer.
This section will be recorded once per pathology report where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
HN9300	HEAD & NECK - PATHOLOGY - VARIOUS	**MAXIMUM DEPTH OF INVASION**	max n3	R
HN9310	HEAD & NECK -PATHOLOGY - VARIOUS	**BONE INVASION** *[BONE INVASION INDICATION CODE]*	an1	R
HN9320	HEAD & NECK - PATHOLOGY - VARIOUS	**CARTILAGE INVASION** *[CARTILAGE INVASION INDICATION CODE]*	an1	R
HN9330	HEAD & NECK - PATHOLOGY - VARIOUS	**NECK DISSECTION LATERALITY** *[ANATOMICAL SIDE (NECK DISSECTION)]*	an1	R

MAXIMUM DEPTH OF INVASION: The maximum depth of invasion in mm. Record as 00 to indicate 'not applicable', (This is not applicable for nasopharynx, hypopharynx, nasal cavity or sinuses).

BONE INVASION [BONE INVASION INDICATION CODE]: Is there evidence of invasion into bone. This is not applicable to many sites as bone not resected.

1	Present
2	Absent
3	Not assessed
4	Not applicable

CARTILAGE INVASION: Is there evidence of invasion into cartilage. This is not applicable to many sites as cartilage is not resected.

1	Present
2	Absent
3	Not assessed
4	Not applicable

NECK DISSECTION LATERALITY: Identify laterality of neck dissection if performed.

1	Left
2	Right
3	Bilateral
4	Not performed
8	Not applicable

8.5 HEAD & NECK – PATHOLOGY – SALIVARY

To carry salivary pathology details for head and neck cancer.
This section will be recorded once per pathology report where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
HN9380	HEAD & NECK - PATHOLOGY - SALIVARY	**HISTOLOGICAL GRADE (SALIVARY TUMOUR)** *[HISTOLOGICAL TUMOUR GRADE (SALIVARY)]*	an1	M
HN9390	HEAD & NECK - PATHOLOGY - SALIVARY	**MACROSCOPIC EXTRAGLANDULAR EXTENSION** *[MACROSCOPIC EXTRAGLANDULAR EXTENSION INDICATION CODE]*	an1	R

HISTOLOGICAL GRADE (SALIVARY TUMOUR): Specify the histological grade of the tumour.

1	Low
2	High
3	Not assessed
4	Not applicable

MACROSCOPIC EXTRAGLANDULAR EXTENSION: Macroscopic extension of tumour outside the capsule of the salivary gland.

1	Present
2	Absent

8.6 HEAD & NECK – PATHOLOGY - GENERAL and SALIVARY

To carry general and salivary pathology details for head and neck cancer.
This section will be recorded once per pathology report where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
HN9400	HEAD & NECK - PATHOLOGY - GENERAL and SALIVARY	**POSITIVE NODES LATERALITY** *[ANATOMICAL SIDE (POSITIVE NODES)]*	an1	M

HN9410	HEAD & NECK - PATHOLOGY - GENERAL and SALIVARY	**LARGEST METASTASIS LEFT NECK** *[LARGEST METASTASIS (LEFT NECK)]*	max n3	R
HN9420	HEAD & NECK - PATHOLOGY - GENERAL and SALIVARY	**LARGEST METASTASIS RIGHT NECK** *[LARGEST METASTASIS (RIGHT NECK)]*	max n3	R
HN9430	HEAD & NECK - PATHOLOGY - GENERAL and SALIVARY	**EXTRACAPSULAR SPREAD** *[EXTRACAPSULAR SPREAD INDICATION CODE]*	an1	R

POSITIVE NODES LATERALITY: If nodes positive specify laterality.

1	Left
2	Right
3	Bilateral
8	Not applicable

LARGEST METASTASIS LEFT NECK: If Neck dissected on Left side, the size in mm of the largest metastasis
LARGEST METASTASIS RIGHT NECK: If Neck dissected on Right side, the size in mm of the largest metastasis.
EXTRACAPSULAR SPREAD: Invasion of metastatic tumour outside the capsule of a lymph node.

1	Present
2	Absent
3	Not assessable

9. LUNG

OVERVIEW

Some items in the Lung site specific dataset may not be available until sometime after the initial record has been uploaded. For surgery patients, treatment record and pathology details may be completed by a different Provider from the First Seen Provider.

Site specific data items have been aligned between the COSD and the National Lung Cancer Audit.

ICD-10 CODES

Key:
() = if applicable
* = different dataset from CWT group specified

ICD-10 All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C33	Malignant neoplasm of trachea	Lung	●			
C34.0	Main bronchus	Lung	●			
C34.1	Upper lobe, bronchus or lung	Lung	●			
C34.2	Middle lobe, bronchus or lung	Lung	●			
C34.3	Lower lobe, bronchus or lung	Lung	●			
C34.8	Overlapping lesion of bronchus and lung	Lung	●			
C34.9	Bronchus or lung, unspecified	Lung	●			
C37	Malignant neoplasm of thymus	Lung	●			
C38.0	Heart	Lung	●			
C38.1	Anterior mediastinum	Lung	●			
C38.2	Posterior mediastinum	Lung	●			
C38.3	Mediastinum, part unspecified	Lung	●			
C38.4	Pleura	Lung	●			

C38.8	Overlapping lesion of heart, mediastinum and pleura	Lung	●			
C39.0	Upper respiratory tract, part unspecified	Lung	●			
C39.8	Overlapping lesion of respiratory and intrathoracic organs	Lung	●			
C39.9	Ill-defined sites within the respiratory system	Lung	●			
C45.0	Mesothelioma of pleura	Lung	●			
C45.1	Mesothelioma of peritoneum	Lung	●			
C45.2	Mesothelioma of pericardium	Lung	●			
C45.7	Mesothelioma of other sites	Lung	●			
C45.9	Mesothelioma, unspecified	Lung	●			
C78.0	Secondary malignant neoplasm of lung	Lung		●		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
C78.1	Secondary malignant neoplasm of mediastinum	Lung		●		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
C78.2	Secondary malignant neoplasm of pleura	Lung		●		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.

C78.3	Secondary malignant neoplasm of other and unspecified respiratory organs	Lung		●		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
D02.1	Carcinoma in situ of Trachea	Lung			●	
D02.2	Carcinoma in situ of Bronchus and lung	Lung			●	
D02.3	Carcinoma in situ of Other parts of respiratory system	Lung			●	
D02.4	Carcinoma in situ of Respiratory system, unspecified	Lung			●	
D38.1	Neoplasm of uncertain or unknown behaviour of Trachea, bronchus and lung	Lung			●	
D38.2	Neoplasm of uncertain or unknown behaviour of Pleura	Lung			●	
D38.3	Neoplasm of uncertain or unknown behaviour of Mediastinum	Lung			●	
D38.4	Neoplasm of uncertain or unknown behaviour of Thymus	Lung			●	
D38.5	Neoplasm of uncertain or unknown behaviour of Other respiratory organs	Lung			●	
D38.6	Neoplasm of uncertain or unknown behaviour of Respiratory organ, unspecified	Lung			●	

9.1 LUNG – IMAGING (CT SCAN)

To carry imaging (CT Scan) details for Lung Carcinoma (to be captured once only for each care pathway) Note this is non-repeating.
This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
LU10000	LUNG - IMAGING (CT SCAN)	**PROCEDURE DATE (CT SCAN)**	an10 ccyy-mm-dd	R
LU10020	LUNG - IMAGING (CT SCAN)	**SCAN PERFORMED INDICATOR (CT)**	an1	R

PROCEDURE DATE (CT SCAN): Date CT scan was performed which informed management of patient at time of MDT

SCAN PERFORMED INDICATOR (CT): Was a CT scan performed on this patient?

Y	Yes
N	No
9	Not known

9.2 LUNG – IMAGING (PET SCAN)

To carry imaging (PET Scan) details for Lung Carcinoma (to be captured once only for each care pathway) Note this is non-repeating.

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
LU10010	LUNG - IMAGING (PET SCAN)	**PROCEDURE DATE (PET CT SCAN)** *[PROCEDURE DATE (PET SCAN)]*	an10 ccyy-mm-dd	R
LU10030	LUNG - IMAGING (PET SCAN)	**SCAN PERFORMED INDICATOR (PET)**	an1	R

PROCEDURE DATE (PET CT SCAN): Date PET CT scan was performed which informed management of patient at time of MDT

SCAN PERFORMED INDICATOR (PET): Was a PET scan performed on this patient?

Y	Yes
N	No
9	Not known

9.3 LUNG – CANCER CARE PLAN

To carry care plan details for Lung Carcinoma. Only one per diagnosis.

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)

LU10040	LUNG - CANCER CARE PLAN	**FEV1 PERCENTAGE** *[FORCED EXPIRATORY VOLUME IN 1 SECOND (PERCENTAGE)]*	max n3	R
LU10050	LUNG - CANCER CARE PLAN	**FEV1 ABSOLUTE VALUE** *[FORCED EXPIRATORY VOLUME IN 1 SECOND (ABSOLUTE AMOUNT)]*	n1.n2	R
LU10190	LUNG - CANCER CARE PLAN	**SMOKING STATUS** *[SMOKING STATUS CODE]*	an1	R
LU10060	LUNG - CANCER CARE PLAN	**MEDIASTINAL SAMPLING INDICATOR**	an1	R

FEV1 PERCENTAGE: The Forced Expiratory Volume in the first second as a percentage of the predicted value.
Must be an integer in the range of 1 to 150

FEV1 ABSOLUTE VALUE: The absolute value of the patient's Forced Expiratory Volume in the first second in litres.

Must be numeric in the range of 0.10 to 9.99.

SMOKING STATUS: Specify the current smoking status of the patient. This data item could be collected at presentation either in the outpatients or on the ward.

1	Current smoker
2	Ex-smoker
3	Non-smoker - history unknown
4	Never smoked
Z	Not Stated (PERSON asked but declined to provide a response)
9	Not known

MEDIASTINAL SAMPLING INDICATOR: Record if the patient had a mediastinoscopy, mediastinotomy, open

Staging Grouping	*T Stage*	*N Stage*	*M Stage*
Stage IA	T1a,b	N0	M0
Stage IB	T2a	N0	M0
Stage IIA	T2b	N0	M0
	T1a,b	N1	M0
	T2a	N1	M0
Stage IIB	T2b	N1	M0
	T3	N0	M0
Stage IIIA	T1a,b,T2a,b	N2	M0
	T3	N1,N2	M0
	T4	N0,N1	M0
Stage IIIB	T4	N2	M0
	Any T	N3	M0
Stage IV	Any T	Any N	M1

mediastinal sampling or other type of mediastinal biopsy (e.g. Endobronchial ultrasound or transbronchial needle aspiration biopsy). This data item will be recorded by the specialist centres.

Y	Yes
N	No
9	Not known

9.4 LUNG – STAGING

UICC LUNG TNM STAGING, SEVENTH EDITION

UICC PLEURAL MESOTHELIOMA TNM STAGING, SEVENTH EDITION

Stage Grouping	*T Stage*	*N Stage*	*M Stage*
Stage IA	T1a	N0	M0
Stage IB	T1b	N0	M0
Stage II	T2	N0	M0
Stage III	T1,T2	N1	M0
	T1,T2	N2	M0
	T3	N0,N1,N2	M0
Stage IV	T4	Any N	M0
	Any T	N3	M0
	Any T	Any N	M1

9.5 LUNG – BRONCHOSCOPY

To carry Bronchoscopy details for Lung Carcinoma (which informed management of patient at time of MDT).
This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
LU10070	LUNG - BRONCHOSCOPY	**PROCEDURE DATE BRONCHOSCOPY** *[PROCEDURE DATE (BRONCHOSCOPY)]*	an10 ccyy-mm-dd	R
LU10080	LUNG - BRONCHOSCOPY	**BRONCHOSCOPY PERFORMED INDICATOR**	an1	R

PROCEDURE DATE BRONCHOSCOPY: Date bronchoscopy was performed which informed management of patient at time of MDT"
BRONCHOSCOPY PERFORMED INDICATOR: Was a bronchoscopy performed on this patient?

Y	Yes
N	No
9	Not known

9.6 LUNG – BIOMARKERS

To carry Biomarker details for Lung Carcinoma.
This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
LU10090	LUNG - BIOMARKERS	**EPIDERMAL GROWTH FACTOR RECEPTOR MUTATIONAL STATUS**	an1	R

EPIDERMAL GROWTH FACTOR RECEPTOR MUTATIONAL STATUS: Epidermal Growth Factor Receptor Mutational Status. This would be available on the results report.

1	Wild type
2	Mutation
3	Failed analysis
4	Not assessed

9.7 LUNG – PATHOLOGY

To carry Pathology details for Lung Carcinoma (Most items are only applicable where patients have surgical resection).
This section can be recorded more than once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
LU10200	LUNG - PATHOLOGY	**INVESTIGATION RESULT DATE**	an10 ccyy-mm-dd	M
LU10210	LUNG - PATHOLOGY	**SERVICE REPORT IDENTIFIER**	max an18	R
LU10100	LUNG - PATHOLOGY	**PROXIMITY TO CARINA** *[TUMOUR PROXIMITY TO CARINA]*	an1	R
LU10110	LUNG - PATHOLOGY	**EXTENT OF ATELECTASIS**	an1	R
LU10120	LUNG - PATHOLOGY	**EXTENT OF PLEURAL INVASION**	an1	R
LU10130	LUNG - PATHOLOGY	**PERICARDIAL INVASION** *[TUMOUR INVASION INDICATOR (PERICARDIUM)]*	an1	R
LU10140	LUNG - PATHOLOGY	**DIAPHRAGM INVASION** *[TUMOUR INVASION INDICATOR (DIAPHRAGM)]*	an1	R
LU10150	LUNG - PATHOLOGY	**INVASION INTO GREAT VESSEL** ***[TUMOUR INVASION INDICATOR (GREAT VESSELS)]***	an1	R
LU10160	LUNG - PATHOLOGY	**INVASION INTO HEART** *[TUMOUR INVASION INDICATOR (HEART)]*	an1	R
LU10170	LUNG - PATHOLOGY	**MALIGNANT PLEURAL EFFUSION** *[MALIGNANT PLEURAL EFFUSION INDICATOR]*	an1	R

LU10180	LUNG - PATHOLOGY	**SATELLITE TUMOUR NODULES LOCATION**	an1	R

INVESTIGATION RESULT DATE: The date on which an investigation was concluded e.g. the date the result was authorised.

SERVICE REPORT IDENTIFIER: A unique identifier of a SERVICE REPORT.

PROXIMITY TO CARINA: Is the tumour within 20mm of carina (if known) or more than 20mm from carina.

1	< 20mm
2	>20mm

EXTENT OF ATELECTASIS: Extent of atelectasis/obstructive pneumonitis.

1	None or less than the two other categories
2	Involving hilar region but not whole lung
3	Involving whole lung

EXTENT OF PLEURAL INVASION: What is the extent of pleural invasion?

1	No pleural invasion
2	Visceral pleura only
3	Parietal pleura/chest wall
4	Mediastinal pleura

PERICARDIAL INVASION: Does the tumour invade the pericardium?

Y	Yes
N	No
9	Not known

DIAPHRAGM INVASION: Does the tumour invade the diaphragm?

Y	Yes
N	No
9	Not known

INVASION INTO GREAT VESSEL: Does the tumour invade the great vessels (aorta, central pulmonary artery or vein)?

Y	Yes
N	No
9	Not known

INVASION INTO HEART: Does the tumour invade the Atrium or Heart?

Y	Yes
N	No
9	Not known

MALIGNANT PLEURAL EFFUSION: Is there evidence of malignant pleural effusion?

Y	Yes
N	No
9	Not known

SATELLITE TUMOUR NODULES LOCATION: Record the most distant location of separate tumour nodules.

1	Separate tumour nodules in same lobe
2	Separate tumour nodules in a different ipsilateral lobe
3	Separate tumour nodules in a contralateral lobe
4	No separate tumour nodules
9	Not known

10. SARCOMA

OVERVIEW

Sarcomas are a rare form of cancer which account for approximately 1% of all malignancies. However, these tumours can arise within any site of the body, implying that some sarcomas will not be included within the ICD-10 site codes listed below.

The Cancer Waiting Times and COSD datasets have consistent inclusion criteria for sarcomas, although the COSD also includes C78.6 ("Secondary malignant neoplasm of retroperitoneum and peritoneum").

As much information as possible is required in order to accurately reflect the sarcoma subsite. For tumours coded under the C46 ICD-10 codes only the CORE dataset needs to be completed.

ICD-10 CODES

Key:

() = if applicable

* = different dataset from CWT group specified

ICD-10 All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C40.0	Scapula and long bones of upper limb	Sarcoma	●			
C40.1	Short bones of upper limb	Sarcoma	●			
C40.2	Long bones of lower limb	Sarcoma	●			
C40.3	Short bones of lower limb	Sarcoma	●			
C40.8	Overlapping lesion of bone and articular cartilage of limbs	Sarcoma	●			
C40.9	Bone and articular cartilage of limb, unspecified	Sarcoma	●			
C41.0	Bones of skull and face	Sarcoma	●			
C41.1	Mandible	Sarcoma	●			
C41.2	Vertebral column	Sarcoma	●			
C41.3	Ribs, sternum and clavicle	Sarcoma	●			
C41.4	Pelvic bones, sacrum and coccyx	Sarcoma	●			

C41.8	Overlapping lesion of bone and articular cartilage	Sarcoma	●			
C41.9	Bone and articular cartilage, unspecified	Sarcoma	●			
C46.0	Kaposi sarcoma of skin	Sarcoma		●		
C46.1	Kaposi sarcoma of soft tissue	Sarcoma		●		
C46.2	Kaposi sarcoma of palate	Sarcoma		●		
C46.3	Kaposi sarcoma of lymph nodes	Sarcoma		●		
C46.7	Kaposi sarcoma of other sites	Sarcoma		●		
C46.8	Kaposi sarcoma of multiple organs	Sarcoma		●		
C46.9	Kaposi sarcoma, unspecified	Sarcoma		●		
C47.0	*Peripheral nerves of head, face and neck*	*Brain/Central Nervous System*		●		*Usually treated by Sarcoma MDT.*
C47.1	*Peripheral nerves of upper limb, including shoulder*	*Brain/Central Nervous System*		●		*Usually treated by Sarcoma MDT.*
C47.2	*Peripheral nerves of lower limb, including hip*	*Brain/Central Nervous System*		●		*Usually treated by Sarcoma MDT.*
C47.3	*Peripheral nerves of thorax*	*Brain/Central Nervous System*		●		*Usually treated by Sarcoma MDT.*
C47.4	*Peripheral nerves of abdomen*	*Brain/Central Nervous System*		●		*Usually treated by Sarcoma MDT.*
C47.5	*Peripheral nerves of pelvis*	*Brain/Central Nervous System*		●		*Usually treated by Sarcoma MDT.*
C47.6	*Peripheral nerves of trunk, unspecified*	*Brain/Central Nervous System*		●		*Usually treated by Sarcoma MDT.*
C47.8	*Overlapping lesion of peripheral nerves and autonomic nervous system*	*Brain/Central Nervous System*		●		*Usually treated by Sarcoma MDT.*
C47.9	*Peripheral nerves and autonomic nervous system, unspecified*	*Brain/Central Nervous System*		●		*Usually treated by Sarcoma MDT.*
C48.0	*Retroperitoneum*	*Sarcoma*	●			*Usually treated by Sarcoma MDT.*

C48.1	*Specified parts of peritoneum*	*Sarcoma*	● *			** Sarcoma and Gynaecology Datasets to be collected where applicable.*
C48.2	*Peritoneum, unspecified*	*Sarcoma*	● *			** Sarcoma and Gynaecology Datasets to be collected where applicable.*
C48.8	Overlapping lesion of retroperitoneum and peritoneum	Sarcoma	●			
C49.0	Connective and soft tissue of head, face and neck	Sarcoma	●			
C49.1	Connective and soft tissue of upper limb, including shoulder	Sarcoma	●			
C49.2	Connective and soft tissue of lower limb, including hip	Sarcoma	●			
C49.3	Connective and soft tissue of thorax	Sarcoma	●			
C49.4	Connective and soft tissue of abdomen	Sarcoma	●			
C49.5	Connective and soft tissue of pelvis	Sarcoma	●			
C49.6	Connective and soft tissue of trunk, unspecified	Sarcoma	●			
C49.8	Overlapping lesion of connective and soft tissue	Sarcoma	●			
C49.9	Connective and soft tissue, unspecified	Sarcoma	●			
C69.6	*Orbit*	*Brain/Central Nervous System*		●		*Not normally treated by CNS MDT. May be treated by Sarcoma MDT.*

C78.6	Secondary malignant neoplasm of retroperitoneum and peritoneum	Sarcoma		●		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
C79.5	Secondary malignant neoplasm of bone and bone marrow	Sarcoma		●		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
D48.0	Neoplasm of uncertain or unknown behaviour of Bone and articular cartilage	Sarcoma			●	
D48.1	Neoplasm of uncertain or unknown behaviour of Connective and other soft tissue	Sarcoma			●	Only applicable for GISTs

10.1 SARCOMA – DIAGNOSIS

To carry diagnosis details for Sarcoma - for both Bone and Soft Tissue.
This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
SA11000	SARCOMA - DIAGNOSIS	**SARCOMA TUMOUR SITE (BONE)**	an4	R
SA11010	SARCOMA - DIAGNOSIS	**SARCOMA TUMOUR SUBSITE (BONE)**	an2	R
SA11080	SARCOMA - DIAGNOSIS	**SARCOMA TUMOUR SITE (SOFT TISSUE)**	an4	R
SA11090	SARCOMA - DIAGNOSIS	**SARCOMA TUMOUR SUBSITE (SOFT TISSUE)**	an2	R
SA11025	SARCOMA - DIAGNOSIS	**MULTIFOCAL OR SYNCHRONOUS TUMOUR INDICATOR**	an1	R

SARCOMA TUMOUR SITE (BONE): Location of the bone sarcoma within the body as defined by OPCS4 code. This is (more specific than ICD10/ICDO3 sites).

Note: Other Z codes may be used if they are felt more appropriate.

Z639	Cranium
Z649	Face
Z659	Jaw
Z663	Cervical Spine
Z664	Thoracic Spine
Z665	Lumbar Spine
Z681	Clavicle
Z684	Glenoid
Z685	Scapula
Z699	Humerus
Z709	Radius
Z719	Ulna
Z724	Carpal
Z732	Metacarpal
Z733	Thumb
Z734	Finger
Z742	Sternum
Z746	Rib
Z751	Sacrum
Z753	Ileum
Z754	Ischium
Z755	Pubis
Z756	Acetabulum
Z757	Coccyx
Z769	Femur
Z779	Tibia
Z786	Fibula
Z787	Patella
Z799	Tarsus
Z802	Metatarsus
Z803	Great toe
Z804	Toe
Z928	Multiple

Note: Use Cranium (Z639) for instances of Sarcoma of the Skull.

SARCOMA TUMOUR SUBSITE (BONE): Sub-location of the bone sarcoma within the tumour site. This gives a more details location of the tumour and should be recorded by specialist centres treating the patient.

PR	Proximal
DS	Distal
DP	Diaphyseal (Middle)
TO	Total
OO	Other
NK	Not known

SARCOMA TUMOUR SITE (SOFT TISSUE): Location of the soft tissue sarcoma within the body as defined by OPCS4 code. This is (more specific than ICD10/ICDO3 sites).

Z272	Stomach
Z301	Liver
Z459	Uterus
Z533	Peritoneum
Z891	Shoulder
Z892	Upper Arm
Z893	Forearm
Z894	Hand
Z898	Specified Arm Region (to include wrist and elbow)
Z901	Buttock
Z903	Upper Leg (to include thigh)
Z904	Lower Leg (to include calf)
Z905	Foot
Z908	Specified leg region (to include groin, knee, ankle)
Z921	Head
Z923	Neck
Z924	Chest (to include Intrathoracic)
Z927	Trunk (to include upper and lower)
Z928	Multiple
Z929	Unknown

Note: Other Z codes may be used if they are felt more appropriate.

SARCOMA TUMOUR SUBSITE (SOFT TISSUE): Sub-location of the soft tissue sarcoma within the tumour site. This gives a more details location of the tumour and should be recorded by specialist centres treating the patient.

RP	Retroperitoneal (subsite of Z53.3)
IP	Intraperitoneal (subsite of Z53.3)
WR	Wrist (subsite of Z89.8)
EB	Elbow (subsite of Z89.8)
UT	Upper Trunk (subsite of Z92.7)
LT	Lower Trunk (subsite of Z92.7)
AD	Adductors (subsite of Z90.3 & Z90.4)
AN	Anterior (subsite of Z90.3 & Z90.4)
PO	Posterior (subsite of Z90.3 & Z90.4)
LA	Lateral (subsite of Z90.3 & Z90.4)
NK	Not Known (No record or Test not carried out)
NA	Not Applicable

MULTIFOCAL OR SYNCHRONOUS TUMOUR INDICATOR: An indicator of the presence of tumours at multiple sites arising synchronously/concurrently.

Y	Yes
N	No
9	Not known

10.2 SARCOMA – STAGE

UICC BONE SARCOMA 2 GRADE SYSTEM, SEVENTH EDITION

Stage Grouping	*T Stage*	*N Stage*	*M Stage*	*Grade*
IA	T1	N0	M0	G1, 2 low grade
IB	T2	N0	M0	G1, 2 low grade
IIA	T1	N0	M0	G3, 4 high grade
IIB	T2	N0	M0	G3, 4 high grade
III	T3	N0	M0	Any G
IVA	Any T	N0	M1a	Any G
IVB	Any T	N1	Any M	Any G
	Any T	Any N	M1b	Any G

UICC SOFT TISSUE SARCOMA 2 GRADE SYSTEM, EDITION

Stage Grouping	*T Stage*	*N Stage*	*M Stage*	*Grade*
IA	T1a or T1b	N0	M0	G1 or G2
IB	T2a	N0	M0	G1 or G2
IIA	T2b	N0	M0	G1 or G2
IIB	T1a or T1b	N0	M0	G3 orG4
IIC	T2a	N0	M0	G3 orG4
III	T2b	N0	M0	G3 orG4
IV	Any T	N1	M0	Any G
	Any T	Any N	M1	Any G

10.3 SARCOMA – PATHOLOGY

To carry pathology details for Sarcoma - for both Bone and Soft Tissue.
This section can be recorded more than once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
SA11200	SARCOMA - PATHOLOGY	**INVESTIGATION RESULT DATE**	an10 ccyy-mm-dd	M
SA11210	SARCOMA - PATHOLOGY	**SERVICE REPORT IDENTIFIER**	max an18	R
SA11120	SARCOMA - PATHOLOGY	**HISTOPATHOLOGICAL TUMOUR GRADE**	an1	R
SA11170	SARCOMA - PATHOLOGY	**GENETIC CONFIRMATION INDICATOR**	an1	R

INVESTIGATION RESULT DATE: The date on which an investigation was concluded e.g. the date the result was authorised.

SERVICE REPORT IDENTIFIER: A unique identifier of a SERVICE REPORT.

HISTOPATHOLOGICAL TUMOUR GRADE: Histopathological grade of tumour.

1	Low
2	Intermediate
3	High

GENETIC CONFIRMATION INDICATOR: Are there any cytogenetic or molecular genetic data confirming the histological diagnosis?

Y	Yes, confirmed
N	No, not confirmed
X	Test not done

10.4 SARCOMA - PATHOLOGY – BONE

To carry pathology details for Sarcoma specific to Bone.
This section will be recorded once per pathology report where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
SA11130	SARCOMA - PATHOLOGY - BONE	**EXTENT OF LOCAL SPREAD (BONE)** *[TUMOUR BREACH IDENTIFIER]*	an1	R
SA11140	SARCOMA - PATHOLOGY - BONE	**TUMOUR NECROSIS**	max n3	R
SA11160	SARCOMA - PATHOLOGY - BONE	**TISSUE TYPE AT NEAREST MARGIN**	an1	R

EXTENT OF LOCAL SPREAD (BONE) [TUMOUR BREACH IDENTIFIER]: FOR MEDULLARY TUMOURS ONLY. Does the tumour breach the cortex. The extent of local spread will determine whether the tumour is intracompartmental or extracompartmental.

I	Intracompartmental
E	Extracompartmental

TUMOUR NECROSIS: Approximate percentage of tumour necrosis in response to pre-operative therapy.
TISSUE TYPE AT NEAREST MARGIN: Type of tissue at nearest excision margin.

1	Normal tissue
2	Pseudocapsule
3	Tumour

10.5 SARCOMA – PATHOLOGY – SOFT TISSUE

To carry pathology details for Sarcoma specific to Soft Tissue.
This section will be recorded once per pathology report where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)

SA11100	SARCOMA - PATHOLOGY - SOFT TISSUE	**TUMOUR DEPTH**	an1	R
SA11220	SARCOMA - PATHOLOGY - SOFT TISSUE	**MITOTIC RATE (SARCOMA)**	max n3	R

TUMOUR DEPTH: Record the deepest tissue compartment where the tumour is located.

1	Intradermal/cutaneous
2	Subcutaneous
3	Fascial/subfascial
9	Not known

MITOTIC RATE (SARCOMA): Mitotic rate per 5mm squared. Also known as mitotic index and mitotic count. Component used to stage GISTs. ONLY APPLICABLE TO GISTs.

11. SKIN

OVERVIEW

As with all other tumour types, pathology reports should be submitted for all skin cancers. It is expected that by January 2014 the pathology reports will include the RCPath cancer data sets, where published, in line with the Royal College of Pathologists professional standards.

Where applicable, the **AJCC STAGE GROUP**, not the UICC **TNM Stage Grouping**, should be collected for stageable skin cancers. Therefore the TNM stage fields which are included in the core dataset are not generally applicable for skin cancers (although basic TNM for skin cancer will still be included in Histopathology Reports.) Please see section 11.3 SKIN – STAGING for further information on how to record AJCC Stage Group.

For Melanomas the full Core and Site Specific datasets must be submitted.

For SCCs and BCCs which require MDT discussion, the full Core and Site Specific datasets must be submitted.

For other non-melanoma* cases which require MDT discussion, only the Core dataset should be submitted. (Where stage is applicable for these cases (e.g. Merkel Cell tumours and Adnexal carcinomas) the AJCC Stage Group should also be recorded as specified in Section 11.3).

For all skin cancers that do not require MDT discussion, the minimum requirement is for the pathology report to be submitted. Providers are encouraged to submit more complete datasets if possible.

Grade of Differentiation is not applicable for skin cancers other than SCC and therefore the two core dataset items, **GRADE OF DIFFERENTIATION (AT DIAGNOSIS)** and **GRADE OF DIFFERENTIATION (PATHOLOGICAL)** are not applicable for Melanoma, BCCs or Merkel Cell tumours.

For PATHOLOGY INVESTIGATION TYPE which is a Core dataset item the following site specific values should be used for skin: Curettage, Shave Biopsy, Punch Biopsy, Incisional Biopsy and Excision.

*Note: Non-melanoma skin cancers include:

- BCC
- SCC
- Merkel Cell tumours
- Adnexal (primary malignant adnexal carcinomas of eccrine, apocrine, follicular and sebaceous subtypes)
- Other NMSC

ICD-10 CODES

Key:

() = if applicable

* = different dataset from CWT group specified

ICD-10 All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C43.0	Malignant melanoma of lip	Skin	●			
C43.1	Malignant melanoma of eyelid, including canthus	Skin	●			

C43.2	Malignant melanoma of ear and external auricular canal	Skin	●			
C43.3	Malignant melanoma of other and unspecified parts of face	Skin	●			
C43.4	Malignant melanoma of scalp and neck	Skin	●			
C43.5	Malignant melanoma of trunk	Skin	●			
C43.6	Malignant melanoma of upper limb, including shoulder	Skin	●			
C43.7	Malignant melanoma of lower limb, including hip	Skin	●			
C43.8	Overlapping malignant melanoma of skin	Skin	●			
C43.9	Malignant melanoma of skin, unspecified	Skin	●			
C44.0	Skin of lip	Skin	(●)	(●)	(●)	See the Skin chapter of the COSD User Guide (Overview Section) for further information on the collection of this Skin disease.
C44.1	Skin of eyelid, including canthus	Skin	(●)	(●)	(●)	See the Skin chapter of the COSD User Guide (Overview Section) for further information on the collection of this Skin disease.

C44.2	Skin of ear and external auricular canal	Skin	(●)	(●)	(●)	See the Skin chapter of the COSD User Guide (Overview Section) for further information on the collection of this Skin disease.
C44.3	Skin of other and unspecified parts of face	Skin	(●)	(●)	(●)	See the Skin chapter of the COSD User Guide (Overview Section) for further information on the collection of this Skin disease.
C44.4	Skin of scalp and neck	Skin	(●)	(●)	(●)	See the Skin chapter of the COSD User Guide (Overview Section) for further information on the collection of this Skin disease.
C44.5	Skin of trunk	Skin	(●)	(●)	(●)	See the Skin chapter of the COSD User Guide (Overview Section) for further information on the collection of this Skin disease.

C44.6	Skin of upper limb, including shoulder	Skin	(●)	(●)	(●)	See the Skin chapter of the COSD User Guide (Overview Section) for further information on the collection of this Skin disease.
C44.7	Skin of lower limb, including hip	Skin	(●)	(●)	(●)	See the Skin chapter of the COSD User Guide (Overview Section) for further information on the collection of this Skin disease.
C44.8	Overlapping lesion of skin	Skin	(●)	(●)	(●)	See the Skin chapter of the COSD User Guide (Overview Section) for further information on the collection of this Skin disease.
C44.9	Malignant neoplasm of skin, unspecified	Skin	(●)	(●)	(●)	See the Skin chapter of the COSD User Guide (Overview Section) for further information on the collection of this Skin disease.
C51.0	*Labium majus*	*Gynaecological*	● *			** Gynaecology and Skin Datasets to be collected where applicable.*

C51.1	*Labium minus*	*Gynaecological*	● *			** Gynaecology and Skin Datasets to be collected where applicable.*
C51.2	*Clitoris*	*Gynaecological*	● *			** Gynaecology and Skin Datasets to be collected where applicable.*
C51.8	*Overlapping lesion of vulva*	*Gynaecological*	● *			** Gynaecology and Skin Datasets to be collected where applicable.*
C51.9	*Vulva, unspecified*	*Gynaecological*	● *			** Gynaecology and Skin Datasets to be collected where applicable.*
C79.2	Secondary malignant neoplasm of skin	Skin		●		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
D03.0	Melanoma in situ of lip	Skin	●			
D03.1	Melanoma in situ of eyelid, including canthus	Skin	●			
D03.2	Melanoma in situ, of ear and external auricular canal	Skin	●			
D03.3	Melanoma in situ of other and unspecified parts of face	Skin	●			
D03.4	Melanoma in situ of scalp and neck	Skin	●			
D03.5	Melanoma in situ of trunk	Skin	●			
D03.6	Melanoma in situ of upper limb, including shoulder	Skin	●			
D03.7	Melanoma in situ of lower limb, including hip	Skin	●			

D03.9	Melanoma in situ, unspecified	Skin	●			
D04.0	Carcinoma in situ of skin of lip	Skin			●	
D04.1	Carcinoma in situ of skin of eyelid, including canthus	Skin			●	
D04.2	Carcinoma in situ of skin of ear and external auricular canal	Skin			●	
D04.3	Carcinoma in situ of skin of other and unspecified parts of face	Skin			●	
D04.4	Carcinoma in situ of skin of scalp and neck	Skin			●	
D04.5	Carcinoma in situ of skin of trunk	Skin			●	
D04.6	Carcinoma in situ of skin of upper limb, including shoulder	Skin			●	
D04.7	Carcinoma in situ of skin of lower limb, including hip	Skin			●	
D04.8	Carcinoma in situ of skin of other sites	Skin			●	
D04.9	Carcinoma in situ of skin, unspecified	Skin			●	
D48.5	Neoplasm of uncertain or unknown behaviour of Skin	Skin			●	

Note: Malignant neoplasm of the anus should be coded as:

- ***Margin (C43.5, C44.5)***
- ***Skin (C43.5, C44.5)***
- ***Perinal skin (C43.5, C44.5)***

11.1 SKIN - GENERAL - BASAL CELL CARCINOMA (BCC), SQUAMOUS CELL CARCINOMA (SCC) and MALIGNANT MELANOMA (MM)

To carry general details for Basal Cell Carcinoma, Squamous Cell Carcinoma, and Malignant Melanoma.
This section can be recorded more than once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
SK12040	SKIN - GENERAL - BCC, SCC & MM	**INVESTIGATION RESULT DATE**	an10 ccyy-mm-dd	M
SK12050	SKIN - GENERAL -	**SERVICE REPORT IDENTIFIER**	max an18	R

	BCC, SCC & MM			
SK12120	SKIN - GENERAL - BCC, SCC & MM	**SKIN CANCER LESION INDICATOR** *[SKIN CANCER LESION NUMBER]*	max an3	R
SK12010	SKIN - GENERAL - BCC, SCC & MM	**GRADE OF CLINICIAN/SURGEON OPERATING** *[CARE PROFESSIONAL SURGEON GRADE (CANCER)]*	an2	R
SK12020	SKIN - GENERAL - BCC, SCC & MM	**SITE CODE OF SPECIMEN** *[SKIN SPECIMEN SITE CODE]*	an4	M
SK12030	SKIN - GENERAL - BCC, SCC & MM	**CLINICAL DIAGNOSIS (PRE-HISTOLOGICAL RESULT - SKIN)** *[SKIN CANCER LESION DIAGNOSIS]*	an2	R

INVESTIGATION RESULT DATE: The date on which an investigation was concluded e.g. the date the result was authorised.

SERVICE REPORT IDENTIFIER: A unique identifier of a SERVICE REPORT.

SKIN CANCER LESION INDICATOR: This is the specimen number or letter used to identify the specimen within a report. Where more than one primary skin cancer is reported on the same pathology report, record the lesion number or letter as specified on the pathology report.

GRADE OF CLINICIAN/SURGEON OPERATING: This is the level of training reached of the actual operating Clinician or Surgeon, and not necessarily the responsible Clinician. This data item could be obtained from the MDT.

NU	NURSE
TS	TRAINEE SPECIALIST DOCTOR
CS	CONSULTANT SURGEON
CD	CONSULTANT DERMATOLOGIST
HP	HOSPITAL PRACTITIONER
SI	GP WITH SPECIAL INTEREST
GP	GENERAL PRACTITIONER
OO	OTHER

SITE CODE OF SPECIMEN: This is the four digit ICD10 code of the skin specimen e.g. C445 = Skin of trunk.

CLINICAL DIAGNOSIS (PRE-HISTOLOGICAL RESULT - SKIN): What is the clinical diagnosis of the patient's lesion/rash.

01	BCC
02	SCC
03	Melanoma
04	Atypical mole
05	Melanocytic tumour (atypical tumour of unknown malignant potential)
06	Other
99	Not known

11.2 SKIN - PATHOLOGY - BASAL CELL CARCINOMA (BCC) and SQUAMOUS CELL CARCINOMA (SCC)

To carry pathology details for Basal Cell Carcinoma and Squamous Cell Carcinoma.

This section will be recorded once per pathology report where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
SK12530	SKIN - PATHOLOGY - BCC & SCC	**PERINEURAL INVASION** *[PERINEURAL INVASION INDICATOR (SKIN)]*	an1	M
SK12537	SKIN - PATHOLOGY - BCC & SCC	**LESION DIAMETER GREATER THAN 20MM INDICATOR**	an1	M
SK12650	SKIN - PATHOLOGY - BCC & SCC	**DEEP INVASION INDICATOR FOR pT3** *[TUMOUR INVASION INDICATOR (PT3)]*	an1	R
SK12660	SKIN - PATHOLOGY - BCC & SCC	**DEEP INVASION INDICATOR FOR pT4** *[TUMOUR INVASION INDICATOR (PT4)]*	an1	R

PERINEURAL INVASION: Invasion into perineurium of nerve bundles.

N	No
Y	Yes
U	Uncertain
X	Not known

LESION DIAMETER GREATER THAN 20MM INDICATOR: Is the diameter of the lesion greater than 20mm?

Y	Yes (Greater than 20mm)
N	No (Less than or equal to 20mm)
9	Not known

DEEP INVASION INDICATOR FOR pT3: For Stage pT3 Tumours only: Tumour with invasion of maxilla, mandible, orbit or temporal bone.

Y	Yes
N	No
U	Uncertain

DEEP INVASION INDICATOR FOR pT4: For Stage pT4 Tumours only: Tumour with invasion of skeleton (axial or appendicular) or perineural invasion of skull base.

Y	Yes
N	No
U	Uncertain

11.3 SKIN – STAGING

Note: TNM stage fields in the Core dataset will not be completed for skin cancers. For Melanoma, SCC and BCC the AJCC Stage Group (7th Edition) is included in the site specific dataset. For other skin cancers (e.g. Merkel Cell tumours and Adnexal carcinomas) the AJCC Stage Group field is the only site specific item that needs to be recorded in addition to the Core dataset.

To carry staging details for Basal Cell Carcinoma, Squamous Cell Carcinoma and Malignant Melanoma.
This section will be recorded once.*

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
SK12510	SKIN - STAGING	**AJCC STAGE GROUP** *[AMERICAN JOINT COMMITTEE ON CANCER STAGE]*	max an2	M

AJCC STAGE GROUP *[AMERICAN JOINT COMMITTEE ON CANCER STAGE]*: *American Joint Committee on Cancer staging of tumour at diagnosis. This is the final integrated stage as agreed by MDT.

Format	*AJCC Stage Group*	*Melanoma*	*Non-melanoma SCC,BCC and Adnexal**	*Merkel cell tumours**
1	I		T1 N0 M0	
1A	IA	T1a N0 M0		T1 pN0 M0
1B	IB	T1b N0 M0		T1 cN0 M0
		T2a N0 M0		
2	II		T2 N0 M0	
2A	IIA	T2b N0 M0		T2/3 pN0 M0
		T3a N0 M0		
2B	IIB	T3b N0 M0		T2/3 cN0 M0
		T4a N0 M0		
2C	IIC	T4b N0 M0		T4 N0 Mo
3	III		3 N0 M0	
			T1,2,3 N1 M0	
3A	IIIA	T1-4a N1a M0		Any T N1a M0
		T1-4a N2a M0		
3B	IIIB	T1-4b N1a M0		
		T1-4b N2a M0		
		T1-4a N1a M0		Any T N1b/N2 Mo
		T1-4a N2b M0		
		T1-4a N2c M0		
3C	IIIC	T1-4b N1b M0		
		T1-4b N2b M0		
		T1-4b N2c M0		
		Any T N3 M0		
4	IV	Any T any N M1	T1,2,3 N2 M0	
			Any T N3 M0	Any T Any N M1
			Any T any N M1	

Note: AJCC Stage Group to be recorded for all skin cancers where applicable. The remaining site specific fields are only currently applicable for Melanoma, SCC and BCC.

11.4 SKIN - PATHOLOGY - SQUAMOUS CELL CARCINOMA (SCC)

To carry pathology details for Squamous Cell Carcinoma.
This section will be recorded once per pathology report where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
SK12545	SKIN - PATHOLOGY - SCC	**CLARKS LEVEL IV INDICATOR**	an1	M

SK12565	SKIN - PATHOLOGY - SCC	**LESION VERTICAL THICKNESS GREATER THAN 2MM INDICATOR**	an1	M

CLARKS LEVEL IV INDICATOR: Greater than or equal to Clark's level IV.

Y	Yes
N	No
X	Not assessable

LESION VERTICAL THICKNESS GREATER THAN 2MM INDICATOR: Is the vertical thickness of the lesion greater than 2mm?

Y	Yes (Greater than 2mm)
N	No, (Less than or equal to 2mm)
9	Not known

11.5 SKIN - PATHOLOGY - MALIGNANT MELANOMA

To carry pathology details for Malignant Melanoma.
This section will be recorded once per pathology report where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
SK12580	SKIN - PATHOLOGY - MM	**ULCERATION INDICATOR**	an1	R
SK12590	SKIN - PATHOLOGY - MM	**MITOTIC RATE (SKIN)**	max n3	R
SK12600	SKIN - PATHOLOGY - MM	**MICROSATELLITE OR IN-TRANSIT METASTASIS INDICATOR**	an1	R
SK12620	SKIN - PATHOLOGY - MM	**TUMOUR REGRESSION INDICATOR**	an1	R
SK12630	SKIN - PATHOLOGY - MM	**BRESLOW THICKNESS**	max n2.max n2	R
SK12430	SKIN - PATHOLOGY - MM	**TUMOUR INFILTRATING LYMPHOCYTES (TILS)** *[TUMOUR INFILTRATING LYMPHOCYTE TYPE]*	an1	R
SK12450	SKIN - PATHOLOGY - MM	**FINAL EXCISION MARGIN AFTER WIDE LOCAL EXCISION**	max n2.max n2	M
SK12460	SKIN - PATHOLOGY - MM	**SENTINEL NODES EXAMINED NUMBER** *[NUMBER OF SENTINEL NODES SAMPLED]*	max n2	M
SK12470	SKIN - PATHOLOGY -	**SENTINEL NODES POSITIVE NUMBER** *[NUMBER OF SENTINEL NODES POSITIVE]*	max n2	M

	MM			
SK12480	SKIN - PATHOLOGY - MM	**POST SNB COMPLETION LYMPHADENECTOMY - NODES SAMPLED NUMBER** *[NUMBER OF SENTINEL NODES SAMPLED (POST SENTINEL NODE COMPLETION LYMPHADENECTOMY]*	max n2	R
SK12490	SKIN - PATHOLOGY - MM	**POST SNB COMPLETION LYMPHADENECTOMY - NODES POSITIVE NUMBER** *[NUMBER OF SENTINEL NODES POSITIVE (POST SENTINEL NODE COMPLETION LYMPHADENECTOMY]*	max n2	R

ULCERATION INDICATOR: Loss of full thickness of epidermis associated with reactive changes (ulceration).

Y	Yes
N	No

MITOTIC RATE (SKIN): Mitotic rate per square millimetres (mm).

Note: May also be known as Mitotic Index or Count.

MICROSATELLITE OR IN-TRANSIT METASTASIS INDICATOR: Is there evidence of Microsatellite or in transit metastases.

Y	Yes
N	No

TUMOUR REGRESSION INDICATOR: Area of loss of tumour associated with reactive changes.

Y	Yes
N	No

BRESLOW THICKNESS: Breslow thickness in mm to nearest 0.01mm.

Note: "Breslow thickness should be measured to a minimum of one decimal place but at times to a greater degree of precision as to allow accurate AJCC staging…. it is essential that the thickness in mm that is recorded in a database should accurately reflect the stated AJCC7 stage.' *(Dataset for the histological reporting of primary cutaneous malignant melanoma and regional lymph nodes (2nd edition) November 2012)*

TUMOUR INFILTRATING LYMPHOCYTES (TILS): Type of TILS. Tumour infiltrating lymphocytes (TILS) are white blood cells that have left the bloodstream and migrated into a tumour.

N	Non-brisk
B	Brisk
A	Absent

FINAL EXCISION MARGIN AFTER WIDE LOCAL EXCISION: Record the final margin of excision, in millimetres (mm's), after wide local excision procedure. This is an amalgamation of clinical and histopathological data.

Note: For COSD reporting purposes, this data item is not required to be submitted to two decimal places.

SENTINEL NODES EXAMINED NUMBER: Number of sentinal nodes sampled.

SENTINEL NODES POSITIVE NUMBER: Number of sentinal nodes positive.

POST SNB COMPLETION LYMPHADENECTOMY - NODES SAMPLED NUMBER: Post SNB completion lymphadenectomy, number of nodes sampled. This procedure is not carried out in all cases.

POST SNB COMPLETION LYMPHADENECTOMY - NODES POSITIVE NUMBER: Post SNB completion lymphadenectomy, number of nodes positive. This procedure is not carried out in all cases.

12. UPPER GI

OVERVIEW

ICD-10 codes C17.1, C17.2, C17.3, C17.8 and C17.9 are grouped under Upper GI for Cancer Waits but are excluded from the COSD Upper GI dataset. For diseases coded under C17.1, C17.2, C17.3, C17.8 and C17.9 only the CORE dataset needs to be completed.

ICD-10 CODES

Key:
() = if applicable
* = different dataset from CWT group specified

ICD-10 All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C15.0	*Cervical part of oesophagus*	*Upper Gastrointestinal*	*			*Usually treated by Head & Neck MDT.*
C15.1	Thoracic part of oesophagus	Upper Gastrointestinal	●			
C15.2	Abdominal part of oesophagus	Upper Gastrointestinal	●			
C15.3	Upper third of oesophagus	Upper Gastrointestinal	●			
C15.4	Middle third of oesophagus	Upper Gastrointestinal	●			
C15.5	Lower third of oesophagus	Upper Gastrointestinal	●			
C15.8	Overlapping lesion of oesophagus	Upper Gastrointestinal	●			
C15.9	Oesophagus, unspecified	Upper Gastrointestinal	●			
C16.0	Cardia	Upper Gastrointestinal	●			
C16.1	Fundus of stomach	Upper Gastrointestinal	●			
C16.2	Body of stomach	Upper Gastrointestinal	●			
C16.3	Pyloric antrum	Upper Gastrointestinal	●			
C16.4	Pylorus	Upper Gastrointestinal	●			

C16.5	Lesser curvature of stomach, unspecified	Upper Gastrointestinal	●			
C16.6	Greater curvature of stomach, unspecified	Upper Gastrointestinal	●			
C16.8	Overlapping lesion of stomach	Upper Gastrointestinal	●			
C16.9	Stomach, unspecified	Upper Gastrointestinal	●			
C17.0	*Duodenum*	*Colorectal*		●		*Usually treated by Upper GI MDT*
C17.1	*Jejunum*	*Colorectal*		●		*Usually treated by Upper GI MDT*
C17.2	*Ileum*	*Colorectal*		●		*Usually treated by Upper GI MDT*
C17.3	*Meckel's diverticulum*	*Colorectal*		●		*Usually treated by Upper GI MDT*
C17.8	*Overlapping lesion of small intestine*	*Colorectal*		●		*Usually treated by Upper GI MDT*
C17.9	*Small intestine, unspecified*	*Colorectal*		●		*Usually treated by Upper GI MDT*
C22.0	Liver cell carcinoma	Upper Gastrointestinal	●			Liver cell carcinoma is also known as HCC.
C22.1	Intrahepatic bile duct carcinoma	Upper Gastrointestinal	●			
C22.2	Hepatoblastoma	Upper Gastrointestinal	●			
C22.3	Angiosarcoma of liver	Upper Gastrointestinal	●			
C22.4	Other sarcomas of liver	Upper Gastrointestinal	●			
C22.7	Other specified carcinomas of liver	Upper Gastrointestinal	●			
C22.9	Liver, unspecified	Upper Gastrointestinal	●			

C23	Malignant neoplasm of gallbladder	Upper Gastrointestinal	●			
C24.0	Extrahepatic bile duct	Upper Gastrointestinal	●			
C24.1	Ampulla of Vater	Upper Gastrointestinal	●			
C24.8	Overlapping lesion of biliary tract	Upper Gastrointestinal	●			
C24.9	Biliary tract, unspecified	Upper Gastrointestinal	●			
C25.0	Head of pancreas	Upper Gastrointestinal	●			
C25.1	Body of pancreas	Upper Gastrointestinal	●			
C25.2	Tail of pancreas	Upper Gastrointestinal	●			
C25.3	Pancreatic duct	Upper Gastrointestinal	●			
C25.4	Endocrine pancreas	Upper Gastrointestinal	●			
C25.7	Other parts of pancreas	Upper Gastrointestinal	●			
C25.8	Overlapping lesion of pancreas	Upper Gastrointestinal	●			
C25.9	Pancreas, unspecified	Upper Gastrointestinal	●			
C78.7	Secondary malignant neoplasm of liver and intrahepetic bile duct	Upper Gastrointestinal		●		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
D00.1	Carcinoma in situ of Oesophagus	Upper Gastrointestinal			●	
D00.2	Carcinoma in situ of Stomach	Upper Gastrointestinal			●	
D01.5	Carcinoma in situ of Liver, gallbladder and bile ducts	Upper Gastrointestinal			●	
D37.1	Neoplasm of uncertain or unknown behaviour of Stomach	Upper Gastrointestinal			●	

D37.2	Neoplasm of uncertain or unknown behaviour of Small intestine	Upper Gastrointestinal			●	
D37.6	Liver, gallbladder and bile ducts	Upper Gastrointestinal			●	

12.1 UPPER GI – CANCER CARE PLAN

To carry cancer care plan details for MAIN Upper GI.
This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
UG13293	UPPER GI - CANCER CARE PLAN	**BODY MASS INDEX**	n2.n1	R

BODY MASS INDEX: Estimate of a patient's Body Mass Index (BMI) at diagnosis. The Body Mass Index (BMI) can be derived by a calculation using the patient's height and weight. This data item would be obtained at presentation either in the outpatient clinic or on the ward.

PERSON OBSERVATION (BMI)

12.2 UPPER GI – CANCER CARE PLAN – LIVER METASTASES

To carry cancer care plan details for Liver Metastases.
This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
UG13630	UPPER GI - CANCER CARE PLAN - LIVER METS	**NUMBER OF LIVER METASTASES (PRE-OPERATIVE IMAGING)**	an1	M

NUMBER OF LIVER METASTASES (PRE-OPERATIVE IMAGING): Total number of liver metastases seen on preoperative imaging.

1	1 to 3
2	4 or more
U	Number uncertain

12.3 UPPER GI – STAGING

UICC OESOPHAGUS INCLUDING OESOPHAGOGASTRIC JUNCTION (ICD-10 C15* - C16.) TNM STAGING, SEVENTH EDITION

Stage Grouping	*T Stage*	*N Stage*	*M Stage*
Stage IA	T1	N0	M0
Stage IB	T2	N0	M0
Stage IIA	T3	M0	M0
Stage IIB	T1,T2	N1	M0
Stage IIIA	T4a	N0	M0
	T3	N1	M0
	T1, T2	N2	M0
Stage IIIB	T3	N2	M0
Stage IIIC	T4a	N1, N2	M0
	T4b	Any N	M0
	Any T	N3	M0
Stage IV	Any T	Any N	M1

UICC STOMACH (INCLUDING FUNDUS OF STOMACH, BODY OF STOMACH, PYLORIC ANTRUM AND PYLORUS) (ICD-10 C16.1 - C16.4) TNM STAGING, SEVENTH EDITION

Stage Grouping	*T Stage*	*N Stage*	*M Stage*
Stage IA	T1	N0	M0
Stage IB	T2	N0	M0
	T1	N1	M0
Stage IIA	T3	N0	M0
	T2	N1	M0
	T1	N2	M0
Stage IIB	T4a	N0	M0
	T3	N1	M0
	T2	N2	M0
	T1	N3	MO
Stage IIIA	T4a	N1	M0
	T3	N2	M0
	T2	N3	M0
Stage IIIB	T4b	N0,N1	M0
	T4a	N2	M0
	T3	N3	M0
Stage IIIC	T4a	N3	M0
	T4b	N2,N3	M0
Stage IV	Any T	Any N	M1

UICC SMALL INTESTINE (ICD-10 C17) TNM STAGING, SEVENTH EDITION

Stage grouping	*T Stage*	*N stage*	*M stage*
Stage I	T1,T2	N0	M0
Stage IIA	T3	N0	M0
Stage IIIB	T4	N0	M0
Stage IIIA	Any T	N1	M0
Stage IIIB	Any T	N2	M0
Stage IV	Any T	Any N	M1

UICC LIVER - HEPATOCELLULAR CARCINOMA (ICD-10 C22.0) TNM STAGING, SEVENTH EDITION

Stage Grouping	*T Stage*	*N stage*	*M Stage*
Stage I	T1	N0	M0
Stage II	T2	N0	M0
Stage IIIA	T3a	N0	M0
Stage IIIB	T3b	N0	M0
Stage IIIC	T4	N0	M0
Stage IVA	Any T	N1	M0
Stage IVB	Any T	Any N	M1

UICC LIVER - INTRAHEPATIC BILE DUCTS (ICD-10 C22.1) TNM STAGING, SEVENTH EDITION

Stage Grouping	*T Stage*	*N Stage*	*M Stage*
Stage I	T1	N0	M0
Stage II	T2	N0	M0
Stage III	T3	N0	M0
Stage IVA	T4	N0	M0
	Any T	N1	M0
Stage IVB	Any T	Any N	M1

UICC GALLBLADDER (ICD-10 C23) TNM STAGING, SEVENTH EDITION

Stage Grouping	*T Stage*	*N Stage*	*M Stage*
Stage I	T1	N0	M0
Stage II	T2	N0	M0
Stage IIIA	T3	N0	M0
Stage IIIB	T1,T2,T3	N1	M0
Stage IVA	T4	Any N	M0
Stage IV	Any T	Any N	M1

UICC EXTRAHEPATIC BILE DUCTS – PERIHILAR (ICD-10 C24.0) TNM STAGING, SEVENTH EDITION

Stage Grouping	*T Stage*	*N Stage*	*M Stage*
Stage I	T1	N0	M0
Stage II	T2a, T2b	N0	M0
Stage IIIA	T3	N0	M0
Stage IIIB	T1,T2,T3	N1	M0
Stage IVA	T4	N0,N1	M0
Stage IVB	Any T	Any N	M1

UICC EXTRAHEPATIC BILE DUCTS – DISTAL (ICD-10 C24.0) TNM STAGING, SEVENTH EDITION

Stage Grouping	*T Stage*	*N Stage*	*M Stage*
Stage IA	T1	N0	M0
Stage IB	T2	N0	M0
Stage IIA	T3	N0	M0
Stage IIB	T1,T2,T3	N1	M0
Stage III	T4	Any N	M0
Stage IV	Any T	Any N	M1

UICC AMPULLA OF VATERS (ICD-10 C24.1) TNM STAGING, SEVENTH EDITION

Stage Grouping	*T Stage*	*N Stage*	*M Stage*

Stage IA	T1	N0	M0
Stage IB	T2	N0	M0
Stage IIA	T3	N0	M0
Stage IIB	T1,T2,T3	N1	M0
Stage III	T4	Any N	M0
Stage IV	Any T	Any N	M1

UICC PANCREAS (ICD-10 C25) TNM STAGING, SEVENTH EDITION

Stage Grouping	*T Stage*	*N Stage*	*M Stage*
Stage IA	T1	N0	M0
Stage IB	T2	N0	M0
Stage IIA	T3	N0	M0
Stage IIB	T1,T2,T3	N1	M0
Stage III	T4	Any N	M0
Stage IV	Any T	Any N	M1

12.4 UPPER GI – MAIN – ENDOSCOPIC OR RADIOLOGICAL PROCEDURES

To carry Endoscopic and Radiological procedures details for Upper GI, as specified.
This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
UG13030	UPPER GI - MAIN - ENDOSCOPIC OR RADIOLOGICAL PROCEDURES	**PROCEDURE DATE (ENDOSCOPIC OR RADIOLOGICAL)**	an10 ccyy-mm-dd	M
UG14410	UPPER GI - O-G - ENDOSCOPIC OR RADIOLOGICAL PROCEDURES	**ORGANISATION SITE CODE (PROVIDER ENDOSCOPIC OR RADIOLOGICAL PROCEDURE)** *[SITE CODE (OF PROVIDER ENDOSCOPIC OR RADIOLOGICAL PROCEDURE)]*	minimum length an5 maximum length an9	M
UG13320	UPPER GI - MAIN - ENDOSCOPIC OR RADIOLOGICAL PROCEDURES	**CONSULTANT CODE (ENDOSCOPIC OR RADIOLOGICAL PROCEDURE)**	an8	R
Start of repeating item - Endoscopic Procedure Type				
UG14290	UPPER GI - PANCREATIC and O-G - SURGERY & OTHER PROCEDURES	**ENDOSCOPIC PROCEDURE TYPE**	an1	R
End of repeating item - Endoscopic Procedure Type				

UG13250	UPPER GI - LIVER CHOLANGIOCARCINOMA - ENDOSCOPIC OR RADIOLOGICAL PROCEDURES	**RADIOLOGICAL PROCEDURE TYPE**	an1	R
UG13070	UPPER GI - LIVER CHOLANGIOCARCINOMA - ENDOSCOPIC OR RADIOLOGICAL PROCEDURES	**INTENT FOR BILIARY STENT** *[BILIARY STENT INSERTION REASON]*	an1	R
UG13080	UPPER GI - LIVER CHOLANGIOCARCINOMA - ENDOSCOPIC OR RADIOLOGICAL PROCEDURES	**SUCCESS OF DEPLOYMENT** *[STENT DEPLOYED SUCCESS INDICATOR]*	an1	R
Start of repeating item - Endoscopic/Radiological Complications				
UG13090	UPPER GI - MAIN --ENDOSCOPIC OR RADIOLOGICAL PROCEDURES	**ENDOSCOPIC OR RADIOLOGICAL COMPLICATION TYPE**	an2	R
End of repeating item - Endoscopic/Radiological Complications				

PROCEDURE DATE (ENDOSCOPIC OR RADIOLOGICAL): The date that the first therapeutic endoscopic/radiological procedure was performed.

ORGANISATION SITE CODE (PROVIDER ENDOSCOPIC OR RADIOLOGICAL PROCEDURE): SITE CODE (OF PROVIDER ENDOSCOPIC OR RADIOLOGICAL PROCEDURE) is the ORGANISATION SITE CODE of the unit providing endoscopic palliative therapy to the PATIENT.

see ORGANISATION SITE CODE

CONSULTANT CODE (ENDOSCOPIC OR RADIOLOGICAL PROCEDURE): The GMC code of the consultant responsible for the endoscopic or radiological procedure

CONSULTANT CODE

ENDOSCOPIC PROCEDURE TYPE: The main endoscopic procedures carried out. More than one procedure can be entered. Repeating Item. For pancreas only values 1, 4 and 8 are valid.

The OG National Audit definition: the main endoscopic techniques performed as part of the first therapeutic endoscopic procedure.

1	Stent insertion
2	Laser therapy
3	Argon plasma coagulation
4	Photodynamic therapy
5	Gastrostomy
6	Brachytherapy
7	Dilation
8	other

RADIOLOGICAL PROCEDURE TYPE: Type of stent or drain inserted by radiological procedure.

1	plastic stent
2	metal stent
3	external biliary drain

INTENT FOR BILIARY STENT: Reason for biliary stent insertion

1	Bridge to surgery
2	Palliation

9	Not known

SUCCESS OF DEPLOYMENT: Whether or not the stent was deployed successfully.

Y	Yes
N	No
9	Not known

ENDOSCOPIC OR RADIOLOGICAL COMPLICATION TYPE: The types of complications that the patient experiences during the admission for the endoscopic procedure. More than one option can be selected.

00	No complications
02	Perforation
03	Haemorrhage
09	Pancreatitis
10	Cholangitis
88	Other

12.5 UPPER GI – SURGICAL PROCEDURES

To carry surgical procedure details for Upper GI, as specified.
This section will be recorded once per treatment where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
UG13235	UPPER GI -SURGICAL PROCEDURES	**ASA SCORE** *[ASA PHYSICAL STATUS CLASSIFICATION SYSTEM CODE]*	an1	R
UG13100	UPPER GI -SURGICAL PROCEDURES	**STAGING LAPAROSCOPY PERFORMED** *[STAGING LAPAROSCOPY PERFORMED INDICATOR]*	an1	M
UG13110	UPPER GI -SURGICAL PROCEDURES	**SURGICAL ACCESS TYPE (ABDOMINAL)**	an1	R
UG14190	UPPER GI - O-G - SURGICAL PROCEDURES	**SURGICAL ACCESS (THORACIC)** *[SURGICAL ACCESS TYPE (THORACIC)]*	an2	R
UG13240	UPPER GI - LIVER CHOLANGIOCARCINOMA and PANCREATIC - SURGICAL PROCEDURES	**SURGICAL PALLIATION TYPE**	an1	R
UG13590	UPPER GI - LIVER HCC - SURGICAL PROCEDURES	**LIVER TRANSPLANTATION** *[LIVER TRANSPLANT PERFORMED INDICATOR]*	an1	R
Start of repeating item - Surgical complications				

UG14210	UPPER GI - O-G - SURGICAL PROCEDURES	**SURGICAL COMPLICATIONS** ***[SURGICAL COMPLICATION TYPE]***	an2	M
End of repeating item - Surgical complications				
UG13150	UPPER GI -SURGICAL PROCEDURES	**UNPLANNED RETURN TO THEATRE INDICATOR** *[UNPLANNED OPERATION INDICATOR]*	an1	R
UG14230	UPPER GI - O-G - SURGICAL PROCEDURES	**POST OPERATIVE TUMOUR SITE (UPPER GI)** *[POST OPERATIVE TUMOUR SITE (UPPER GASTROINTESTINAL)]*	an2	R
UG13810	UPPER GI - SURGICAL PROCEDURES	**PALLIATIVE TREATMENT REASON (UPPER GI)** *[PALLIATIVE TREATMENT REASON CODE (UPPER GASTROINTESTINAL)]*	an1	R

ASA SCORE: The ASA physical status classification system is a system for assessing the fitness of patients before surgery.

1	A normal healthy patient.
2	A patient with mild systemic disease.
3	A patient with severe systemic disease
4	A patient with severe systemic disease that is a constant threat to life.
5	A moribund patient who is not expected to survive without the operation.
6	A declared brain-dead patient whose organs are being removed for donor purposes

STAGING LAPAROSCOPY PERFORMED: Record whether a staging laparoscopy was performed. This may include an intraoperative ultrasound which is performed at some centres.

Y	Yes
N	No
9	Not known

SURGICAL ACCESS TYPE (ABDOMINAL): The approach used to perform the abdominal part of the main procedure.
For Oesophagectomy can have:
Open laparotomy (abdomen) and thoracoscopic (chest)
Laparoscopic (abdomen) and open thoracotomy (chest)

Laparoscopic (abdomen) and thoracoscopic (chest)

1	Open operation
2	Laparoscopic with planned conversion to open surgery
3	Laparoscopic with unplanned conversion to open surgery
4	Laparoscopic completed

SURGICAL ACCESS (THORACIC): The approach used to perform the thoracic part of the main procedure.

01	Open operation

02	Thoracoscopic converted to open
03	Thoracoscopic completed
NA	Not applicable

SURGICAL PALLIATION TYPE: Type of surgical palliation performed if any e.g. Hepaticojejunostomy

0	None
1	gastric bypass
2	biliary bypass
3	gastric/biliary bypass
4	celiac plexus block
9	Not known

LIVER TRANSPLANTATION: Was a liver transplant performed?

Y	Yes
N	No

SURGICAL COMPLICATIONS: The types of post-operative complications that the patient experiences between the time of the operation, and his / her discharge from hospital or death. A complication is defined as a development of clinical significance that requires intervention (i.e. alteration in the patient's management plan). NB re-operation, radiological intervention or readmission to critical care is NOT required.

00	No complications
01	Pneumonia
02	Acute respiratory distress syndrome (ARDS)
03	Pulmonary embolism
04	Pleural effusion
05	Anastomotic leak
06	Chyle leak
07	Haemorrhage
08	Cardiac complication
09	Acute renal failure
10	Wound infection
11	liver failure
13	gastric outlet obstruction
14	pancreatic leak
15	biliary leak
16	gastric anastomotic leak
17	pancreatic endocrine insufficiency
18	pancreatic exocrine insufficiency
19	early delayed gastric emptying
20	Duodenal suture line leak
21	Anastomotic stricture
98	Other
99	Not known

UNPLANNED RETURN TO THEATRE INDICATOR: Whether or not the patient required a second (unplanned) operation during the same admission as the primary procedure.

Y	Yes

N	No
9	Not known

POST OPERATIVE TUMOUR SITE (UPPER GI): The main cancer site for which the patient is receiving care, as established in the resected specimen. Please note that "Cardia" should no longer be used to describe adenocarcinomas located at the gastro-oesophageal junction. Instead, these tumours should be described by the appropriate Siewert type.

01	Oesophagus upper third
02	Oesophagus middle third
03	Oesophagus lower third
04	Siewert 1
05	Siewert 2
06	Siewert 3
07	Fundus
08	Body of stomach
09	Antrum
10	Pylorus

PALLIATIVE TREATMENT REASON (UPPER GI): Rationale for palliative treatment.

1	Extensive intrahepatic disease
2	Widespread disease
3	Both extensive intrahepatic and widespread disease
4	Biliary obstruction
5	Gastric outlet obstruction
6	Pain

12.6 UPPER GI – LIVER METASTASES and LIVER HEPATOCELLULAR CARCINOMA

To carry other procedure details for Liver Metastases and Liver Carcinoma.
This section will be recorded once per treatment where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
UG13560	UPPER GI - LIVER METS and LIVER HCC	**ABLATIVE THERAPY TYPE**	an1	M
UG13580	UPPER GI - LIVER METS and LIVER HCC	**TRANS ARTERIAL CHEMOEMBOLISATION** *[TRANS ARTERIAL CHEMOEMBOLISATION PERFORMED INDICATOR]*	an1	M

ABLATIVE THERAPY TYPE: Describe type of ablative (i.e. locally destructive treatment) therapy used if any. This procedure would be performed in the endoscopy unit. Please check local policies.

N	None
R	Radiofrequency ablation
O	Other ablative treatment
9	Not known

TRANS ARTERIAL CHEMOEMBOLISATION: Was Trans Arterial Chemoembolisation (TACE) carried out? This procedure would be performed in the specialist centres.

Y	Yes
N	No
9	Not known

12.7 UPPER GI - PATHOLOGY

To carry pathology details for various Upper GI cancers as shown.
This section can be recorded more than once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
UG14500	UPPER GI - PATHOLOGY - LIVER METS	**INVESTIGATION RESULT DATE**	an10 ccyy-mm-dd	M
UG14510	UPPER GI - PATHOLOGY - LIVER METS	**SERVICE REPORT IDENTIFIER**	max an18	R
UG14470	UPPER GI - PATHOLOGY - LIVER METS	**NUMBER OF COLORECTAL METASTASES IN LIVER CODE**	an1	R
UG14480	UPPER GI - PATHOLOGY - OESOPHAGEAL AND STOMACH	**EXCISION MARGIN (PROXIMAL, DISTAL)** *[MARGIN INVOLVED INDICATION CODE (POSITIVE PROXIMAL OR DISTAL RESECTION MARGIN)]*	an1	R
UG14490	UPPER GI - PATHOLOGY - OESOPHAGEAL, OG JUNCTION, PANCREAS, BILE DUCT, LCC, LIVER HCC AND LIVER METS	**EXCISION MARGIN (CIRCUMFERENTIAL)** *[MARGIN INVOLVED INDICATION CODE (CIRCUMFERENTIAL MARGIN)]*	an1	R

INVESTIGATION RESULT DATE: The date on which an investigation was concluded e.g. the date the result was authorised.
SERVICE REPORT IDENTIFIER: A unique identifier of a SERVICE REPORT.
NUMBER OF COLORECTAL METASTASES IN LIVER CODE: Number of colorectal metastases identified in resected liver.

0	None
1	1
2	2
3	3
4	4
5	5
M	Greater than 5

EXCISION MARGIN (PROXIMAL, DISTAL): Identify whether either proximal or distal margin is involved. (Involved equals 1mm or less, not involved equals greater than 1mm).

0	Margin not involved

1	Margin involved
9	Not known

EXCISION MARGIN (CIRCUMFERENTIAL): Identify whether circumferential margin is involved. (Involved equals 1mm or less, not involved equals greater than 1mm).

0	Margin not involved
1	Margin involved
9	Not known

13. UROLOGY

OVERVIEW

The site specific Urology dataset applies additionally to in situ Bladder cancers (D09.0) and pTa Bladder cancers (D41.4), although these are excluded from Cancer Waits.

Watchful Waiting and Active Surveillance

A treatment (CANCER TREATMENT MODALITY) of "Active Monitoring" should be recorded for all patients who are largely asymptomatic and may progress to active treatment if the status of the disease progresses. (This covers all patients who are being monitored only and will include "watchful waiting" as used clinically). In order to distinguish between the above two groups of patients, the field MONITORING INTENT should be completed as follows:

- Active surveillance/monitoring - Use Code 1 "Monitoring with future curative intent"
- Watchful waiting - Use Code 2 "Monitoring with future palliative intent"
- If unable to distinguish, use Code 3 "Monitoring with unknown or uncertain future intent"

For symptomatic patients who are not receiving active treatment , the selected treatment type (CANCER TREATMENT MODALITY) will be either "Specialist Palliative Care" or "Non specialist Palliative Care" depending on whether the patient is under the care of a specialist in palliative medicine.

ICD-10 CODES

Key:

() = if applicable

* = different dataset from CWT group specified

ICD-10 All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C60.0	*Prepuce*	*Urological*	● *			** Urology and Skin Datasets to be collected where applicable.*
C60.1	*Glans penis*	*Urological*	● *			** Urology and Skin Datasets to be collected where applicable.*
C60.2	*Body of penis*	*Urological*	● *			** Urology and Skin Datasets to be collected where applicable.*

C60.8	*Overlapping lesion of penis*	*Urological*	● *			** Urology and Skin Datasets to be collected where applicable.*
C60.9	*Penis, unspecified*	*Urological*	● *			** Urology and Skin Datasets to be collected where applicable.*
C61	Malignant neoplasm of prostate	Urological	●			
C62.0	Undescended testis	Urological	●			
C62.1	Descended testis	Urological	●			
C62.9	Testis, unspecified	Urological	●			
C63.0	Epididymis	Urological	●			
C63.1	Spermatic cord	Urological	●			
C63.2	Scrotum	Urological		●		
C63.7	Other specified male genital organs	Urological	●			
C63.8	Overlapping lesion of male genital organs	Urological	●			
C63.9	Male genital organ, unspecified	Urological	●			
C64	Malignant neoplasm of kidney, except renal pelvis	Urological	●			
C65	Malignant neoplasm of renal pelvis	Urological	●			
C66	Malignant neoplasm of ureter	Urological	●			
C67.0	Trigone of bladder	Urological	●			
C67.1	Dome of bladder	Urological	●			
C67.2	Lateral wall of bladder	Urological	●			
C67.3	Anterior wall of bladder	Urological	●			
C67.4	Posterior wall of bladder	Urological	●			
C67.5	Bladder neck	Urological	●			
C67.6	Ureteric orifice	Urological	●			
C67.7	Urachus	Urological	●			
C67.8	Overlapping lesion of bladder	Urological	●			

C67.9	Bladder, unspecified	Urological	●			
C68.0	Urethra	Urological	●			
C68.1	Paraurethral glands	Urological	●			
C68.8	Overlapping lesion of urinary organs	Urological	●			
C68.9	Urinary organ, unspecified	Urological	●			
C79.0	Secondary malignant neoplasm of kidney and renal pelvis	Urological		●		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
C79.1	Secondary malignant neoplasm of bladder and other and unspecified urinary organs	Urological		●		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
D07.4	carcinoma in situ of penis	Urological			●	
D07.5	carcinoma in situ of prostate	Urological			●	
D07.6	carcinoma in situ of other and unspecified male genital organs	Urological			●	
D09.0	Carcinoma in situ of Bladder	Urological	●			
D09.1	carcinoma in situ of other and unspecified urinary organs	Urological			●	
D40.0	Neoplasm of uncertain or unknown behaviour of prostate	Urological			●	
D40.1	Neoplasm of uncertain or unknown behaviour of testis	Urological			●	
D40.7	Neoplasm of uncertain or unknown behaviour of other male genital organs	Urological			●	

D40.9	Neoplasm of uncertain or unknown behaviour of male genital organs, unspecifed	Urological			●	
D41.0	Neoplasm of uncertain or unknown behaviour of kidney	Urological			●	
D41.1	Neoplasm of uncertain or unknown behaviour of renal pelvis	Urological	●			
D41.2	Neoplasm of uncertain or unknown behaviour of ureter	Urological	●			
D41.3	Neoplasm of uncertain or unknown behaviour of urethra	Urological	●			
D41.4	Neoplasm of uncertain or unknown behaviour of bladder	Urological	●			
D41.7	Neoplasm of uncertain or unknown behaviour of other urinary organs	Urological			●	
D41.9	Neoplasm of uncertain or unknown behaviour of urinary organs, unspecified	Urological			●	

*For tumours in unusual sites where there is overlap between a dataset based on anatomy and another based on the disease description it is recommended that both datasets are completed. For example, for a melanoma of the penis both the penile and the melanoma dataset should be completed.

13.1 UROLOGY - CANCER CARE PLAN

To carry the cancer care plan details for Urology. There may be a number of cancer care plans, on different dates.
This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
UR15000	UROLOGY - CANCER CARE PLAN	**ESTIMATED GLOMERULAR FILTRATION RATE**	max n2	R
UR15010	UROLOGY - CANCER CARE PLAN	**HYDRONEPHROSIS** *[HYDRONEPHROSIS CODE]*	an1	R
UR15020	UROLOGY - CANCER CARE PLAN	**NORMAL LDH** *[LACTATE DEHYDROGENASE LEVEL (NORMAL UPPER LIMIT)]*	max n6	R
UR15030	UROLOGY - CANCER CARE PLAN	**S-CATEGORY** *[S CATEGORY CODE]*	an2	R
UR15040	UROLOGY - CANCER CARE PLAN	**S-CATEGORY AFP** *[S CATEGORY (ALPHA FETOPROTEIN)]*	max n6	R
UR15050	UROLOGY - CANCER CARE PLAN	**S-CATEGORY HCG** *[S CATEGORY (HUMAN CHORIONIC GONADOTROPIN)]*	max n7	R
UR15060	UROLOGY - CANCER CARE PLAN	**S-CATEGORY LDH** *[S CATEGORY (LACTATE DEHYDROGENASE)]*	max n6	R
UR15070	UROLOGY - CANCER CARE PLAN	**PSA (DIAGNOSIS)** *[PROSTATE SPECIFIC ANTIGEN (DIAGNOSIS)]*	max n5.n1	R

ESTIMATED GLOMERULAR FILTRATION RATE: RENAL ONLY. This is the estimated Glomerular Filtration Rate. It is a measurement of kidney function in mls/min/1.73m2. This is to be collected once at diagnosis. Note that this should be recorded as part of standard renal function test. Positive values. Numerical value to be recorded (categories can be derived from this at a later stage) (0-99)

HYDRONEPHROSIS [HYDRONEPHROSIS CODE]: BLADDER ONLY. Consequence of reduced outflow of urine from Kidney. May be present in one or both kidneys.

0	None
L	Left
R	Right
B	Bilateral
8	Not Applicable (No Kidneys)
9	Not Known

NORMAL LDH: TESTICULAR ONLY. This is the upper limit of normal for the LDH (Lactate Dehydrogenase Level) assay which is used to calculate S Category. Range 0 – 999999.

S-CATEGORY: TESTICULAR ONLY. Based on serum tumour markers AFP, HCG and LDH. For Testicular Cancer S category is an additional prognostic factor.

See below for further details of values to be recorded.

SX	Tumour marker studies not available or not performed
S0	Tumour marker levels within normal limits
S1	LDH < 1.5 X Normal and HCG (mIu/ml) < 5000 and AFP (ug/ml) < 1000
S2	LDH 1.5-10 X Normal or HCG (mIu/ml) 5000-50,000 or AFP (ug/ml) 1000-10,000
S3	LDH > 10 X Normal or HCG (mIu/ml) > 50,000 or AFP (ug/ml) > 10,000

S-CATEGORY AFP: TESTICULAR ONLY. Alpha Feto-Protein (AFP) is a serum tumour marker. Where normal are values recorded this will be collected once at diagnosis by specialist MDT. If abnormal at diagnosis the lowest measurement prior to chemotherapy or radiotherapy should be recorded. If no chemotherapy or radiotherapy is given, where markers are abnormal record lowest measurement post orchidectomy. Range 0 – 999999.
S-CATEGORY HCG: TESTICULAR ONLY. Human Chorionic Gonadotropin (HCG) is a serum tumour marker. Where normal values are recorded this will be collected once at diagnosis by specialist MDT. If abnormal at diagnosis the lowest measurement prior to chemotherapy or radiotherapy should be recorded. If no chemotherapy or radiotherapy is given, where markers are abnormal record lowest measurement post orchidectomy. To be collected once at diagnosis by specialist MDT. Range 0 – 999999.
S-CATEGORY LDH: TESTICULAR ONLY. Serum Lactate Dehydrogenase (LDH) is a serum tumour marker. Where normal values are recorded this will be collected once at diagnosis by specialist MDT. If abnormal at diagnosis the lowest measurement prior to chemotherapy or radiotherapy should be recorded. If no chemotherapy or radiotherapy is given, where markers are abnormal record lowest measurement post orchidectomy. Range 0 – 999999.
PSA (DIAGNOSIS): PROSTATE ONLY. Prostate Specific Antigen blood level in ng/ml, measured at time of diagnosis.

13.2 UROLOGY – STAGING – TESTICULAR

For testicular cancer ideally RMH stage grouping and TNM stage components should both be collected. UICC stage groupings should not be used as they do not map to RMH stage. Pre-treatment TNM Stage components are optional. S category should be collected separately. First CT Scan performed (usually after orchidectomy) prior to chemotherapy/radiotherapy should be reported in the Core Imaging section.

Note: Although International Germ Cell Consensus (IGCC) Prognostic Groupings largely supersedes RHM Staging for testicular cancer (except for seminomas), the NCIN Urology SSRCG has agreed that RHM Staging should continue to be used for staging testicular cancer for the near future. Further consideration on how stage is collected for testicular cancers in the future will be considered again when the COSD is next reviewed.

To carry staging details for Testicular.
This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
UR15300	UROLOGY - STAGING - TESTICULAR	**STAGE GROUPING (TESTICULAR)** *[STAGE GROUPING (TESTICULAR CANCER)]*	max an2	M
Start of repeating item - Extra-nodal metastases				
UR15320	UROLOGY - STAGING - TESTICULAR	**EXTRANODAL METASTASES** *[EXTENT OF METASATIC SPREAD]*	an1	R
End of repeating item - Extra-nodal metastases				
UR15330	UROLOGY - STAGING - TESTICULAR	**LUNG METASTASES SUB-STAGE GROUPING**	an2	R

STAGE GROUPING (TESTICULAR): TESTICULAR ONLY. Nationally agreed anatomical stage groupings as defined by The Royal Marsden Hospital (RMH).

1	Stage 1	Confined to testis
1S	Stage 1S	(Not used)
1M	Stage 1M	Rising post orchidectomy markers only
2A	Stage 2A	Abdominal lymphadenopathy < 2cm
2B	Stage 2B	Abdominal lymphadenopathy 2cm – 5cm
2C	Stage 2C	Abdominal lymphadenopathy > 5cm
3A	Stage 3A	Supradiaphragmatic lymphadenopathy with abdominal lymphadenopathy < 2cm
3B	Stage 3B	Supradiaphragmatic lymphadenopathy with abdominal lymphadenopathy 2cm – 5cm
3C	Stage 3C	Supradiaphragmatic lymphadenopathy with abdominal lymphadenopathy > 5cm
4A	Stage 4A	Extralymphatic metastases with abdominal lymphadenopathy < 2cm
4B	Stage 4B	Extralymphatic metastases with abdominal lymphadenopathy 2cm – 5cm
4C	Stage 4C	Extralymphatic metastases with abdominal lymphadenopathy > 5cm

EXTRANODAL METASTASES: (FOR TESTICULAR STAGE 4 PATIENTS ONLY). Indicate the extent of metastatic spread (multiple items can be selected).

Note: This data item only applies to a small cohort of patients.

H	Liver involvement
B	Brain involvement
M	Mediastinal involvement
N	Neck nodes
L	Lung involvement

LUNG METASTASES SUB-STAGE GROUPING: (FOR TESTICULAR CANCER ONLY). Where lung metastases are identified, specify the RMH grouping.

Note: This only applies to a very small sub group with Extra-Nodal Metastases.

L1	Less than or equal to 3 metastases
L2	Greater than 3 metastases
L3	Greater than 3 metastases, one or more greater than or equal to 2cm diameter

UICC CARCINOMA OF THE TESTIS TNM STAGING, SEVENTH EDITION (STAGE COMPONENTS ONLY)

TNM T Clinical Classification - Apart for a pT4 where radical orchidectomy is not always necessary for classification purposes, the extent of the primary tumour is classified after radical orchidectomy; see pT below. In other circumstances, TX is used if no radical orchidectomy has been performed.

Primary Tumour	
pT0	No evidence of primary tumour (e.g. histological scar in testis)
pTis	Intratubular germ cell neoplasia
pT1	Tumour limited to testis and epididymis without vascular/lymphatic invasion; tumour may invade tunica albuginea but not tunica vaginalis
pT2	Tumour limited to testis and epididymis with vascular/lymphatic invasion, or tumour extending

	through tunica albuginea with involvement of tunica vaginalis
pT3	Tumour invades spermatic cord with or without vascular/lymphatic invasion
pT4	Tumour invades scrotum with or without vascular/lymphatic invasion
Regional Lymph Nodes	
N0 & pN0	No regional lymph node metastasis
N1 & pN1	Metastasis with a lymph node mass 2cm or less in greatest dimension or 5 or fewer positive lymph nodes, none more than 2cm in greatest dimension
N2	Metastasis with a lymph node mass more than 2cm but not more than 5cm in greatest dimension; or 5 or fewer positive lymph nodes, none more than 5cm in greatest dimension
pN2	Metastasis with a lymph node mass more than 2cm but not more than 5cm in greatest dimension; or 5 or fewer positive lymph nodes, none more than 5cm in greatest dimension; or evidence of extranodal extension of tumour
N3 &pN3	Metastasis with a lymph node mass more than 5cm in greatest dimension
Distant Metastasis	
M0	No distant metastasis
M1a	Non-regional lymph nodes or lung
M1b	Other sites

13.3 UROLOGY – STAGING – RENAL PELVIS AND URETER

UICC CARCINOMA OF THE RENAL AND URETER TNM STAGING, SEVENTH EDITION

Stage Grouping	***T Stage***	***N Stage***	***M Stage***
Stage I	T1	N0	M0
Stage II	T2	N0	M0
Stage III	T3	N0	M0
Stage IV	T4	N0	M0
	Any T	N1, N2, N3	M0
	Any T	Any N	M1

Note: (p) indicates also applicable for pathological stage

Primary Tumour	
(p)T0	No evidence of primary tumour.
(p)Ta	Non-invasive papillary carcinoma.
(p)Tis	Carcinoma in situ.
(p)T1	Tumour invades subepithelial connective tissue.
(p)T2	Tumour invades muscularis.
(p)T3	(Renal pelvis) Tumour invades beyond muscularis into peripelvic fat or renal parenchyma. (Ureter) Tumour invades beyond muscularis into periureteric fat.
(p)T4	Tumour invades adjacent organs or through the kidney into perinephric fat.
Regional Lymph Nodes	
(p)NX	Regional lymph nodes cannot be assessed.
(p)N0	No regional lymph node metastasis.
(p)N1	Metastasis in a single lymph node 2 cm or less in greatest dimension.
(p)N2	Metastasis in a single lymph node more than 2 cm but not more than 5 cm in greatest dimension,

	or multiple lymph nodes, none more than 5 cm in greatest dimension.
(p)N3	Metastasis in a lymph node more than 5 cm in greatest dimension.
Distant Metastasis	
M0	No distant metastasis.
(p)M1	Distant metastasis.

13.4 UROLOGY – STAGING – URINARY BLADDER

UICC CARCINOMA OF THE URINARY BLADDER TNM STAGING, SEVENTH EDITION

Stage Grouping	***T Stage***	***N Stage***	***M Stage***
Stage I	T1	N0	M0
Stage II	T2a,b	N0	M0
Stage III	T3a,b	N0	M0
	T4a	N0	M0
Stage IV	T4b	N0	M0
	Any T	N1, N2, N3	M0
	Any T	Any N	M1

Primary Tumour	
Ta	Non-invasive papillary carcinoma
Tis	Carcinoma in-situ: 'flat tumour'
T1	Tumour invades subepithelial connective tissue
T2a	Tumour invades superficial muscle (inner half)
T2b	Tumour invades deep muscle (outer half)
T3a	Tumour invades perivesical tissue: Microscopically
T3b	Tumour invades perivesical tissue: Macroscopically (extravesical mass)
T4a	Tumour invades prostate stroma, seminal vesicles, uterus or vagina
T4b	Tumour invades pelvic wall or abdominal wall
Regional Lymph Nodes	
N0	No regional lymph node metastasis
N1	Metastasis in a single lymph node in the true pelvis (hypogastric, obturator, external iliac or presacral)
N2	Metastasis in multiple lymph nodes in the true pelvis (hypogastric, obturator, external iliac or presacral)
N3	Metastasis in a common iliac lymph node(s)
Distant Metastasis	
M0	No distant metastasis.
M1	Distant metastasis.

Note: Recording Bladder stage following neoadjuvant therapy

For cases of bladder or urethral cancer treated by cystectomy, problems will be encountered where neoadjuvant therapy is used. TNM stage will be dependent on histological examination of the resected specimen together with information obtained from radiological imaging etc. Wherever possible TNM with the "y" prefix (NEOADJUVANT THERAPY INDICATOR) should be used for pathology stage fields. For all other cases, where no operation is performed, staging will have to be based on radiological appearances either before or after the neo-adjuvant treatment and an integrated TNM stage decided based on the radiological appearances.

13.5 UROLOGY – STAGING – URETHRA

UICC CARCINOMA OF THE URETHRA (MALE AND FEMALE) TNM STAGING, SEVENTH EDITION

Note: (p) indicates also applicable for pathological stage

(p)Ta	Non-invasive papillary, polypoid or verrucous carcinoma.*
(p)Tis	Carcinoma in situ.
(p)T1	Tumour invades subepithelial connective tissue.
(p)T2	Tumour invades any of the following: corpus spongiosum, prostate, periurethral muscle.
(p)T3	Tumour invades any of the following: corpus cavernosum, beyond prostatic capsule, anterior vagina, bladder neck.
(p)T4	Tumour invades other adjacent organs. 15

Note: Most verrucous carcinomas arise from penile skin rather than urethra; readers are referred to the penile dataset for clarification.

Note: Recording Urethra stage following neoadjuvant therapy

For cases of bladder or urethral cancer treated by cystectomy, problems will be encountered where neoadjuvant therapy is used. TNM stage will be dependent on histological examination of the resected specimen together with information obtained from radiological imaging etc. Wherever possible TNM with the "y" prefix (NEOADJUVANT THERAPY INDICATOR) should be used for pathology stage fields. For all other cases, where no operation is performed, staging will have to be based on radiological appearances either before or after the neo-adjuvant treatment and an integrated TNM stage decided based on the radiological appearances.

UICC TRANSITIONAL CELL CARCINOMA OF THE PROSTATE (PROSTATIC URETHRA) TNM STAGING, SEVENTH EDITION

Stage Grouping	*T Stage*	*N Stage*	*M Stage*
Stage I	T1	N0	M0
Stage II	T2	N0	M0
Stage III	T1, T2	N1	M0
	T3	N0,N1	M0
Stage IV	T4	N0, N1	M0
	Any T	N2	M0
	Any T	Any N	M1

Note: (p) indicates also applicable for pathological stage

Primary Tumour	
(p)Tis pu	Carcinoma in situ, involvement of prostatic urethra.
(p)Tis pd	Carcinoma in situ, involvement of prostatic ducts.
(p)T1	Tumour invades subepithelial connective tissue.
(p)T2	Tumour invades any of the following: prostatic stroma, corpus spongiosum, periurethral muscle.
(p)T3	Tumour invades any of the following: corpus cavernosum, beyond prostatic capsule, bladder neck (extraprostatic extension).
(p)T4	Tumour invades other adjacent organs (invasion of bladder).
Regional Lymph Nodes	
(p)Nx	Regional lymph nodes cannot be assessed.
(p)N0	No regional lymph node metastasis.

(p)N1	Metastasis in a single lymph node 2 cm or less in greatest dimension.
(p)N2	Metastasis in a single lymph node more than 2 cm or multiple lymph nodes.
Distant Metastasis	
(p)M0	No distant metastasis.
(p)M1	Distant metastasis.

13.6 UROLOGY – STAGING – PROSTATE

UICC ADENOCARCINOMA OF THE PROSTATE TNM STAGING, SEVENTH EDITION

Stage Grouping	*T Stage*	*N Stage*	*M Stage*
Stage I	T1, T1a, T1b, T1c, T2a	N0	M0
Stage II	T2b, T2c	N0	M0
Stage III	T3, T3a, T3b	N1	M0
Stage IV	T4	N0	M0
	ANY T	N1	M0
	ANY T	ANY N	M1

Note: (p) indicates also applicable for pathological stage

Primary Tumour	
T1	Clinically inapparent tumour, neither palpable nor visible by imaging
T1a	Tumour incidental histological finding in 5% or less of tissue resected
T1b	Tumour incidental histological finding in more than 5% of tissue resected
T1c	Tumour identified by needle biopsy, e.g. because of elevated prostate-specific antigen (PSA)
(p)T2	Tumour confined within prostate
(p)T2a	Tumour involves one-half of one lobe or less
(p)T2b	Tumour involves more than one-half of one lobe, but not both lobes
(p)T2c	Tumour involves both lobes
(p)T3	Tumour extends through the prostatic capsule
(p)T3a	Extracapsular extension (unilateral or bilateral) including microscopic bladder neck involvement
(p)T3b	Tumour invades seminal vesicle(s)
(p)T4	Tumour is fixed or invades adjacent structures other than seminal vesicles: external sphincter, rectum, levator muscles, and/or pelvic wall
Regional Lymph Nodes	
(p)NX	Regional lymph nodes cannot be assessed
(p)N0	No regional lymph node metastasis
(p)N1	Regional lymph node metastasis
Distant Metastasis	
M0	No distant metastasis
(p)M1	Distant metastasis
(p)M1a	Non-regional lymph node(s)
(p)M1b	Bone(s)
(p)M1c	Other site(s)

Note: Recording Prostate stage following neoadjuvant therapy

For cases of prostate cancer treated by prostatectomy, problems will be encountered where neoadjuvant therapy (usually hormones) is used. TNM stage will be dependent on histological examination of the resected specimen together with information obtained from radiological imaging etc. Wherever possible TNM with the "y" prefix (NEOADJUVANT THERAPY INDICATOR) should be used for pathology stage fields. For all other cases, where no operation is performed, staging will have to be based on radiological appearances either before or after the neo-adjuvant treatment and an integrated TNM stage decided based on the radiological appearances.

13.7 UROLOGY – STAGING – KIDNEY

UICC RENAL CELL CARCINOMA OF THE KIDNEY TNM STAGING, SEVENTH EDITION

Stage Grouping	*T Stage*	*N Stage*	*M Stage*
Stage I	T1	N0	M0
Stage II	T2	N0	M0
Stage III	T3	Any N	M0
	T1, T2, T3	N1	M1
Stage IV	T4	Any N	M0
	Any T	Any N	M1

Primary Tumour	
T1	Tumour 7cm or less in greatest dimension, limited to the kidney
T1a	Tumour 4cm or less
T1b	Tumour more than 4cm but not more than 7cm
T2a	Tumour is more than 7cm in greatest dimension, but not more than 10cm, limited to the kidney
T2b	Tumour is more than 10cm in greatest dimension, limited to the kidney
T3a	Tumour grossly extends into the renal vein or its segmental (muscle containing) branches, or tumour invades perirenal and/or renal sinus fat (periplexic) fat but not beyond Gerota fascia
T3b	Tumour grossly extends into vena cava below diaphragm
T3c	Tumour grossly extends into vena cava above diaphragm
T4	Tumour invades beyond Gerota fascia (including contiguous extension into the ipsilateral adrenal gland)
Regional Lymph Nodes	
N0	No regional lymph node metastasis
N1	Metastasis in a single regional lymph node
N2	Metastasis in a single regional lymph node
Distant Metastasis	
M0	No distant metastasis
M1	Distant metastasis

Note: Recording Kidney stage following preoperative drug therapy

For cases of kidney cancer treated with surgery, problems will be encountered where preoperative drug therapy (usually biological targeted therapy) is used. TNM stage will be dependent on histological examination of the resected specimen together with information obtained from radiological imaging etc. Wherever possible TNM with the "y" prefix (NEOADJUVANT THERAPY INDICATOR) should be used for pathology stage fields. For all other cases, where no operation is performed, staging will have to be based

on radiological appearances either before or after preoperative drug therapy and an integrated TNM stage decided based on the radiological appearances.

13.8 UROLOGY – STAGING – PENIS

UICC CARCINOMA OF THE PENIS TNM STAGING, SIXTH EDITION

Stage Grouping	*T Stage*	*N Stage*	*M Stage*
Stage 0	Tis	N0	M0
Stage 0	Ta	N0	M0
Stage I	T1	N0	M0
	T1a	N0	M0
Stage II	T1b	N0	M0
	T2	N0	M0
	T3	N0	M0
Stage IIIA	T1, T2, T3	N1	M0
Stage IIIB	T1, T2, T3	N2	M0
Stage IV	T4	Any N	M0
	Any T	N3	M0
	Any T	Any N	M1

Primary Tumour	
Tis	Carcinoma in situ
Ta	Non-invasive verrucous carcinoma
T1a	Tumour invades subepithelial connective tissue without lymphovascular invasion or is poorly differentiated or undifferentiated
T1b	Tumour invades subepithelial connective tissue with lymphovascular invasion or is poorly differentiated or undifferentiated
T2	Tumour invades corpus spongiosum or caverneosum
T3	Tumour invades urethra
T4	Tumour invades adjacent structures
Regional Lymph Nodes	
N0	No palpable or visibly enlarges inguinal lymph nodes
N1	Palpable mobile unilateral inguinal lymph node
N2	Palpable mobile multiple or bilateral inguinal lymph nodes
N3	Fixed inguinal lymph nodal mass or pelvic lymphadenopathy unilateral or bilateral
Distant Metastasis	
M0	No distant metastasis
M1	Distant metastasis

Note: Recording Penis stage following neoadjuvant therapy

For cases of penis cancer treated with surgery, problems will be encountered where preoperative chemotherapy is used. TNM stage will be dependent on histological examination of the resected specimen together with information obtained from radiological imaging etc. Wherever possible TNM with the "y" prefix (NEOADJUVANT THERAPY INDICATOR) should be used for pathology stage fields. For all other cases,

where no operation is performed, staging will have to be based on radiological appearances either before or after the preoperative chemotherapy and an integrated TNM stage decided based on the radiological appearances.

13.9 UROLOGY – TREATMENT – BLADDER

To carry the cancer treatment details for Bladder.
This section will be recorded once per treatment where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
UR15100	UROLOGY - TREATMENT - BLADDER	**INTRAVESICAL CHEMOTHERAPY RECEIVED INDICATOR**	an1	M[13]
UR15110	UROLOGY - TREATMENT - BLADDER	**INTRAVESICAL IMMUNOTHERAPY RECEIVED INDICATOR**	an1	M[14]

Note: Either* INTRAVESICAL CHEMOTHERAPY RECEIVED INDICATOR *or* INTRAVESICAL IMMUNOTHERAPY RECEIVED INDICATOR *is required if applicable.

INTRAVESICAL CHEMOTHERAPY RECEIVED INDICATOR: BLADDER ONLY. (Only required for patients having chemotherapy). Record as YES for patients having intravesical chemotherapy to distinguish from intravenous. This data items requires clinical involvement to ensure completeness.

Y	Yes
N	No
9	Not known

INTRAVESICAL IMMUNOTHERAPY RECEIVED INDICATOR: BLADDER ONLY. (Only required for patients having immunotherapy). Record as YES for patients having immunotherapy to distinguish from systemic. This data items requires clinical involvement to ensure completeness.

Y	Yes
N	No
9	Not known

13.10 UROLOGY – TREATMENT – PROSTATE

To carry the cancer treatment details for Prostate.
This section will be recorded once per treatment where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
UR15080	UROLOGY - TREATMENT -	**PSA (PRE-TREATMENT)**	max	M

[13] Either **INTRAVESICAL CHEMOTHERAPY RECEIVED INDICATOR** or **INTRAVESICAL IMMUNOTHERAPY RECEIVED INDICATOR** is Mandatory for the schema.

[14] Either **INTRAVESICAL IMMUNOTHERAPY RECEIVED INDICATOR** or **INTRAVESICAL CHEMOTHERAPY RECEIVED INDICATOR** is Mandatory for the schema.

	PROSTATE	*[PROSTATE SPECIFIC ANTIGEN (PRE TREATMENT)]*	n5.n1	

PSA (PRE-TREATMENT): PROSTATE ONLY. Prostate Specific Antigen blood level in ng/ml, measured before treatment (including second and subsequent treatments). This is the PSA taken prior to EACH treatment (because some curative treatments may be delivered years after diagnosis.

13.11 UROLOGY – PATHOLOGY – GENERAL

To carry general pathology details for Urology cancer.
This section can be recorded more than once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
UR15340	UROLOGY - PATHOLOGY - GENERAL	**INVESTIGATION RESULT DATE**	an10 ccyy-mm-dd	M
UR15350	UROLOGY - PATHOLOGY - GENERAL	**SERVICE REPORT IDENTIFIER**	max an18	R

INVESTIGATION RESULT DATE: The date on which an investigation was concluded e.g. the date the result was authorised.
SERVICE REPORT IDENTIFIER: A unique identifier of a SERVICE REPORT.

13.12 UROLOGY – PATHOLOGY – BLADDER

To carry the cancer pathology details for Bladder.
This section will be recorded once per pathology report where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
UR15120	UROLOGY - PATHOLOGY - BLADDER	**DETRUSOR MUSCLE PRESENCE INDICATOR** *[DETRUSOR MUSCLE PRESENCE INDICATION CODE]*	an1	M

DETRUSOR MUSCLE PRESENCE INDICATOR: BLADDER ONLY Presence or absence of detrusor muscle in the specimen.

13.13 UROLOGY – PATHOLOGY – KIDNEY

To carry the cancer pathology details for Kidney.
This section will be recorded once is permitted per pathology report where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)

UR15130	UROLOGY - PATHOLOGY - KIDNEY	**TUMOUR NECROSIS INDICATOR**	an1	R
UR15140	UROLOGY - PATHOLOGY - KIDNEY	**PERINEPHRIC FAT INVASION** *[TUMOUR INVASION INDICATOR (PERINEPHRIC FAT)]*	an1	R
UR15150	UROLOGY - PATHOLOGY - KIDNEY	**ADRENAL INVASION** *[TUMOUR INVASION INDICATOR (ADRENAL)]*	an1	R
UR15160	UROLOGY - PATHOLOGY - KIDNEY	**RENAL VEIN TUMOUR** *[RENAL VEIN TUMOUR INDICATOR]*	an1	R
UR15170	UROLOGY - PATHOLOGY - KIDNEY	**GEROTA'S FASCIA INVASION** *[TUMOUR INVASION INDICATOR (GEROTAS FASCIA)]*	an1	R

TUMOUR NECROSIS INDICATOR: Is there evidence of coagulative tumour necrosis?

Y	Yes
N	No

PERINEPHRIC FAT INVASION: Is there evidence of perinephric fat invasion?

Y	Yes
N	No

ADRENAL INVASION: Is there evidence of direct adrenal invasion?

Y	Yes
N	No

RENAL VEIN TUMOUR: Is there evidence of tumour thrombus in the renal vein?

Y	Yes
N	No

GEROTA'S FASCIA INVASION: Is there evidence of invasion into Gerota's fascia?

Y	Yes
N	No

13.14 UROLOGY – PATHOLOGY – PENIS

To carry the cancer pathology details for Penis.
This section will be recorded once per pathology report where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
UR15180	UROLOGY-PATHOLOGY - PENIS	**CORPUS SPONGIOSUM INVASION** *[TUMOUR INVASION INDICATOR (CORPUS SPONGIOSUM)]*	an1	R
UR15190	UROLOGY-	**CORPUS CAVERNOSUM INVASION**	an1	R

	PATHOLOGY - PENIS	*[TUMOUR INVASION INDICATOR (CORPUS CAVERNOSUM)]*		
UR15200	UROLOGY-PATHOLOGY - PENIS	**URETHRA OR PROSTATE INVASION** *[TUMOUR INVASION INDICATOR (URETHRA OR PROSTATE)]*	an1	R

CORPUS SPONGIOSUM INVASION: Is there evidence of invasion into corpus spongiosum?

Y	Yes
N	No

CORPUS CAVERNOSUM INVASION: Is there evidence of invasion into corpus cavernosum?

Y	Yes
N	No

URETHRA OR PROSTATE INVASION: Is there evidence of invasion into the urethra or prostate?

Y	Yes
N	No

13.15 UROLOGY – PATHOLOGY – PROSTATE

To carry the cancer pathology details for Prostate.
This section will be recorded once per pathology report where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
UR15210	UROLOGY - PATHOLOGY - PROSTATE	**GLEASON GRADE (PRIMARY)**	an1*	M
UR15220	UROLOGY - PATHOLOGY - PROSTATE	**GLEASON GRADE (SECONDARY)**	an1*	R
UR15230	UROLOGY - PATHOLOGY - PROSTATE	**GLEASON GRADE (TERTIARY)**	an1*	R
UR15240	UROLOGY - PATHOLOGY - PROSTATE	**PERINEURAL INVASION** *[PERINEURAL INVASION INDICATOR (UROLOGY)]*	an1	R
UR15250	UROLOGY - PATHOLOGY - PROSTATE	**ORGAN CONFINED** *[ORGAN CONFINED INDICATOR]*	an1	R
UR15260	UROLOGY - PATHOLOGY - PROSTATE	**SEMINAL VESICLES INVASION** *[TUMOUR INVASION INDICATOR (SEMINAL VESICLES)]*	an1	R
UR15270	UROLOGY - PATHOLOGY - PROSTATE	**TURP TUMOUR PERCENTAGE**	max n3	R

**Format an1 used to align with Data Dictionary rules.*

Applies to the next three data items:

The Gleason Grading System is a system for CANCER STAGING.

The Gleason Grading System is used to help evaluate the prognosis of men with prostate cancer.

A pathologist assigns a Gleason grade to the most common tumour pattern in a biopsy specimen (Primary Grade) then the second most common (Secondary Grade). The grades are added together to give the Gleason Score.

Sometimes pathologists will also give a grade to a third component of the specimen (Tertiary Grade) although this recorded separately and is not added to the score.

GLEASON GRADE (PRIMARY): What is the most extensive Gleason grade?

1 - 5	Range 1-5

GLEASON GRADE (SECONDARY): If additional grades are present, what is the highest grade (biopsy) or the second most extensive grade (TURP and radicals). If no additional grades are present, primary and secondary grades are the same.

1 - 5	Range 1-5

GLEASON GRADE (TERTIARY): Is there a different third grade in addition the primary and secondary grades and what is its value? Note that this is only applicable to about 5% of prostate cases.

1 - 5	Range 1 - 5
8	Not applicable

PERINEURAL INVASION: Is there perineural invasion (PNI)?

Y	Yes
N	No
X	Not assessable

ORGAN CONFINED: If prostatectomy was performed, is the tumour confined to the prostate?

Y	Yes
N	No
X	Not applicable

SEMINAL VESICLES INVASION: If prostatectomy was performed, is there invasion into Seminal Vesicles?

Y	Yes
N	No
X	Not applicable

TURP TUMOUR PERCENTAGE: For TURP only, what percentage of tumour if clinically unsuspected tumour. Range 0 - 100

13.16 UROLOGY – PATHOLOGY – BLADDER

To carry the cancer pathology details for bladder.
This section will be recorded once per pathology report where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
UR15290	UROLOGY - PATHOLOGY - BLADDER	**TUMOUR GRADE (UROLOGY)**	an1	M

TUMOUR GRADE (UROLOGY): BLADDER ONLY. Specify whether LOW, HIGH Grade or PUNLMP (Papillary Urothelial Neoplasm of Low Maligant Potential).

L	Low
H	High
P	Punlmp
X	Not applicable

13.17 UROLOGY – PATHOLOGY – TESTICULAR

To carry the cancer pathology details for Testicular.
This section will be recorded once per pathology report where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
UR15310	UROLOGY - PATHOLOGY - TESTICULAR	**RETE TESTES INVASION** *[TUMOUR INVASION INDICATOR (RETE TESTIS)]*	an1	R

RETE TESTES INVASION: For Seminoma only, does the tumour invade the rete testis?

Y	Yes
N	No
X	Not applicable

APPENDIX A – Cancer Waiting Times ICD10 Codes and Tumour Groups for Primary Diagnoses

(Applicable from April 2012)

Notes:

The following table lists all the registerable diseases by ICD10 code, together with the expected dataset to be completed and the potential stage.

This table provides general guidelines only as not all permutations can be covered and there will always be exceptions. Local clinical input is essential to identify and complete the appropriate stage.

Further guidance is available from your local cancer registration service office.

Key:

() = if applicable

* = different dataset from CWT group specified

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C00.0	External upper lip	Head and Neck		●		
C00.1	External lower lip	Head and Neck		●		
C00.2	External lip, unspecified	Head and Neck		●		
C00.3	Upper lip, inner aspect	Head and Neck	●			
C00.4	Lower lip, inner aspect	Head and Neck	●			
C00.5	Lip, unspecified, inner aspect	Head and Neck	●			
C00.6	Commissure of lip	Head and Neck	●			
C00.8	Overlapping lesion of lip	Head and Neck	●			
C00.9	Lip, unspecified	Head and Neck	●			
C01	Malignant neoplasm of base of tongue	Head and Neck	●			
C02.0	Dorsal surface of tongue	Head and Neck	●			
C02.1	Border of tongue	Head and Neck	●			
C02.2	Ventral surface of tongue	Head and Neck	●			
C02.3	Anterior two-thirds of tongue, part unspecified	Head and Neck	●			
C02.4	Lingual tonsil	Head and Neck	●			
C02.8	Overlapping lesion of tongue	Head and Neck	●			
C02.9	Tongue, unspecified	Head and Neck	●			
C03.0	Upper gum	Head and Neck	●			

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C03.1	Lower gum	Head and Neck	●			
C03.9	Gum, unspecified	Head and Neck	●			
C04.0	Anterior floor of mouth	Head and Neck	●			
C04.1	Lateral floor of mouth	Head and Neck	●			
C04.8	Overlapping lesion of floor of mouth	Head and Neck	●			
C04.9	Floor of mouth, unspecified	Head and Neck	●			
C05.0	Hard palate	Head and Neck	●			
C05.1	Soft palate	Head and Neck	●			
C05.2	Uvula	Head and Neck	●			
C05.8	Overlapping lesion of palate	Head and Neck	●			
C05.9	Palate, unspecified	Head and Neck	●			
C06.0	Cheek mucosa	Head and Neck	●			
C06.1	Vestibule of mouth	Head and Neck	●			
C06.2	Retromolar area	Head and Neck	●			
C06.8	Overlapping lesion of other and unspecified parts of mouth	Head and Neck	●			
C06.9	Mouth, unspecified	Head and Neck	●			
C07	Malignant neoplasm of parotid gland	Head and Neck	●			
C08.0	Submandibular gland	Head and Neck	●			
C08.1	Sublingual gland	Head and Neck	●			
C08.8	Overlapping lesion of major salivary glands	Head and Neck	●			
C08.9	Major salivary gland, unspecified	Head and Neck	●			
C09.0	Tonsillar fossa	Head and Neck	●			
C09.1	Tonsillar pillar (anterior) (posterior)	Head and Neck	●			
C09.8	Overlapping lesion of tonsil	Head and Neck	●			
C09.9	Tonsil, unspecified	Head and Neck	●			
C10.0	Vallecula	Head and Neck	●			
C10.1	Anterior surface of epiglottis	Head and Neck	●			
C10.2	Lateral wall of oropharynx	Head and Neck	●			

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C10.3	Posterior wall of oropharynx	Head and Neck	●			
C10.4	Branchial cleft	Head and Neck	●			
C10.8	Overlapping lesion of oropharynx	Head and Neck	●			
C10.9	Oropharynx, unspecified	Head and Neck	●			
C11.0	Superior wall of nasopharynx	Head and Neck	●			
C11.1	Posterior wall of nasopharynx	Head and Neck	●			
C11.2	Lateral wall of nasopharynx	Head and Neck	●			
C11.3	Anterior wall of nasopharynx	Head and Neck	●			
C11.8	Overlapping lesion of nasopharynx	Head and Neck	●			
C11.9	Nasopharynx, unspecified	Head and Neck	●			
C12	Malignant neoplasm of pyriform sinus	Head and Neck	●			
C13.0	Postcricoid region	Head and Neck	●			
C13.1	Aryepiglottic fold, hypopharyngeal aspect	Head and Neck	●			
C13.2	Posterior wall of hypopharynx	Head and Neck	●			
C13.8	Overlapping lesion of hypopharynx	Head and Neck	●			
C13.9	Hypopharynx, unspecified	Head and Neck	●			
C14.0	Pharynx, unspecified	Head and Neck	●			
C14.2	Waldeyer's ring	Head and Neck	●			
C14.8	Overlapping lesion of lip, oral cavity and pharynx	Head and Neck	●			
C15.0	*Cervical part of oesophagus*	*Upper Gastrointestinal*	*			*Usually treated by Head & Neck MDT.*
C15.1	Thoracic part of oesophagus	Upper Gastrointestinal	●			
C15.2	Abdominal part of oesophagus	Upper Gastrointestinal	●			
C15.3	Upper third of oesophagus	Upper Gastrointestinal	●			

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C15.4	Middle third of oesophagus	Upper Gastrointestinal	●			
C15.5	Lower third of oesophagus	Upper Gastrointestinal	●			
C15.8	Overlapping lesion of oesophagus	Upper Gastrointestinal	●			
C15.9	Oesophagus, unspecified	Upper Gastrointestinal	●			
C16.0	Cardia	Upper Gastrointestinal	●			
C16.1	Fundus of stomach	Upper Gastrointestinal	●			
C16.2	Body of stomach	Upper Gastrointestinal	●			
C16.3	Pyloric antrum	Upper Gastrointestinal	●			
C16.4	Pylorus	Upper Gastrointestinal	●			
C16.5	Lesser curvature of stomach, unspecified	Upper Gastrointestinal	●			
C16.6	Greater curvature of stomach, unspecified	Upper Gastrointestinal	●			
C16.8	Overlapping lesion of stomach	Upper Gastrointestinal	●			
C16.9	Stomach, unspecified	Upper Gastrointestinal	●			
C17.0	*Duodenum*	*Colorectal*		●		*Usually treated by Upper GI MDT*
C17.1	*Jejunum*	*Colorectal*		●		*Usually treated by Upper GI MDT*
C17.2	*Ileum*	*Colorectal*		●		*Usually treated by Upper GI MDT*
C17.3	*Meckel's diverticulum*	*Colorectal*		●		*Usually treated by Upper GI MDT*
C17.8	*Overlapping lesion of small intestine*	*Colorectal*		●		*Usually treated by Upper GI MDT*

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C17.9	*Small intestine, unspecified*	*Colorectal*		●		*Usually treated by Upper GI MDT*
C18.0	Caecum	Colorectal	●			
C18.1	Appendix	Colorectal		●		
C18.2	Ascending colon	Colorectal	●			
C18.3	Hepatic flexure	Colorectal	●			
C18.4	Transverse colon	Colorectal	●			
C18.5	Splenic flexure	Colorectal	●			
C18.6	Descending colon	Colorectal	●			
C18.7	Sigmoid colon	Colorectal	●			
C18.8	Overlapping lesion of colon	Colorectal	●			
C18.9	Colon, unspecified	Colorectal	●			
C19	Malignant neoplasm of rectosigmoid junction	Colorectal	●			
C20	Malignant neoplasm of rectum	Colorectal	●			
C21.0	Anus, unspecified	Colorectal		●		
C21.1	Anal canal	Colorectal		●		
C21.2	Cloacogenic zone	Colorectal		●		
C21.8	Overlapping lesion of rectum, anus and anal canal	Colorectal		●		
C22.0	Liver cell carcinoma	Upper Gastrointestinal	●			Liver cell carcinoma is also known as HCC.
C22.1	Intrahepatic bile duct carcinoma	Upper Gastrointestinal	●			
C22.2	Hepatoblastoma	Upper Gastrointestinal	●			
C22.3	Angiosarcoma of liver	Upper Gastrointestinal	●			
C22.4	Other sarcomas of liver	Upper Gastrointestinal	●			
C22.7	Other specified carcinomas of liver	Upper Gastrointestinal	●			
C22.9	Liver, unspecified	Upper Gastrointestinal	●			
C23	Malignant neoplasm of gallbladder	Upper Gastrointestinal	●			

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C24.0	Extrahepatic bile duct	Upper Gastrointestinal	●			
C24.1	Ampulla of Vater	Upper Gastrointestinal	●			
C24.8	Overlapping lesion of biliary tract	Upper Gastrointestinal	●			
C24.9	Biliary tract, unspecified	Upper Gastrointestinal	●			
C25.0	Head of pancreas	Upper Gastrointestinal	●			
C25.1	Body of pancreas	Upper Gastrointestinal	●			
C25.2	Tail of pancreas	Upper Gastrointestinal	●			
C25.3	Pancreatic duct	Upper Gastrointestinal	●			
C25.4	Endocrine pancreas	Upper Gastrointestinal	●			
C25.7	Other parts of pancreas	Upper Gastrointestinal	●			
C25.8	Overlapping lesion of pancreas	Upper Gastrointestinal	●			
C25.9	Pancreas, unspecified	Upper Gastrointestinal	●			
C26.0	Intestinal tract, part unspecified	Colorectal	●			
C26.1	Spleen	Colorectal		●		
C26.8	Overlapping lesion of digestive system	Colorectal		●		
C26.9	Ill-defined sites within the digestive system	Colorectal		●		
C30.0	Nasal cavity	Head and Neck	●			
C30.1	Middle ear	Head and Neck	●			
C31.0	Maxillary sinus	Head and Neck	●			
C31.1	Ethmoidal sinus	Head and Neck	●			
C31.2	Frontal sinus	Head and Neck	●			
C31.3	Sphenoidal sinus	Head and Neck	●			
C31.8	Overlapping lesion of accessory sinuses	Head and Neck	●			
C31.9	Accessory sinus, unspecified	Head and Neck	●			
C32.0	Glottis	Head and Neck	●			
C32.1	Supraglottis	Head and Neck	●			
C32.2	Subglottis	Head and Neck	●			

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C32.3	Laryngeal cartilage	Head and Neck	●			
C32.8	Overlapping lesion of larynx	Head and Neck	●			
C32.9	Larynx, unspecified	Head and Neck	●			
C33	Malignant neoplasm of trachea	Lung	●			
C34.0	Main bronchus	Lung	●			
C34.1	Upper lobe, bronchus or lung	Lung	●			
C34.2	Middle lobe, bronchus or lung	Lung	●			
C34.3	Lower lobe, bronchus or lung	Lung	●			
C34.8	Overlapping lesion of bronchus and lung	Lung	●			
C34.9	Bronchus or lung, unspecified	Lung	●			
C37	Malignant neoplasm of thymus	Lung	●			
C38.0	Heart	Lung	●			
C38.1	Anterior mediastinum	Lung	●			
C38.2	Posterior mediastinum	Lung	●			
C38.3	Mediastinum, part unspecified	Lung	●			
C38.4	Pleura	Lung	●			
C38.8	Overlapping lesion of heart, mediastinum and pleura	Lung	●			
C39.0	Upper respiratory tract, part unspecified	Lung	●			
C39.8	Overlapping lesion of respiratory and intrathoracic organs	Lung	●			
C39.9	Ill-defined sites within the respiratory system	Lung	●			
C40.0	Scapula and long bones of upper limb	Sarcoma	●			
C40.1	Short bones of upper limb	Sarcoma	●			
C40.2	Long bones of lower limb	Sarcoma	●			
C40.3	Short bones of lower limb	Sarcoma	●			

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C40.8	Overlapping lesion of bone and articular cartilage of limbs	Sarcoma	●			
C40.9	Bone and articular cartilage of limb, unspecified	Sarcoma	●			
C41.0	Bones of skull and face	Sarcoma	●			
C41.1	Mandible	Sarcoma	●			
C41.2	Vertebral column	Sarcoma	●			
C41.3	Ribs, sternum and clavicle	Sarcoma	●			
C41.4	Pelvic bones, sacrum and coccyx	Sarcoma	●			
C41.8	Overlapping lesion of bone and articular cartilage	Sarcoma	●			
C41.9	Bone and articular cartilage, unspecified	Sarcoma	●			
C43.0	Malignant melanoma of lip	Skin	●			
C43.1	Malignant melanoma of eyelid, including canthus	Skin	●			
C43.2	Malignant melanoma of ear and external auricular canal	Skin	●			
C43.3	Malignant melanoma of other and unspecified parts of face	Skin	●			
C43.4	Malignant melanoma of scalp and neck	Skin	●			
C43.5	Malignant melanoma of trunk	Skin	●			
C43.6	Malignant melanoma of upper limb, including shoulder	Skin	●			
C43.7	Malignant melanoma of lower limb, including hip	Skin	●			
C43.8	Overlapping malignant melanoma of skin	Skin	●			
C43.9	Malignant melanoma of skin, unspecified	Skin	●			

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C44.0	Skin of lip	Skin	(●)	(●)	(●)	See the Skin chapter of the COSD User Guide (Overview Section) for further information on the collection of this Skin disease.
C44.1	Skin of eyelid, including canthus	Skin	(●)	(●)	(●)	See the Skin chapter of the COSD User Guide (Overview Section) for further information on the collection of this Skin disease.
C44.2	Skin of ear and external auricular canal	Skin	(●)	(●)	(●)	See the Skin chapter of the COSD User Guide (Overview Section) for further information on the collection of this Skin disease.
C44.3	Skin of other and unspecified parts of face	Skin	(●)	(●)	(●)	See the Skin chapter of the COSD User Guide (Overview Section) for further information on the collection of this Skin disease.

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C44.4	Skin of scalp and neck	Skin	(●)	(●)	(●)	See the Skin chapter of the COSD User Guide (Overview Section) for further information on the collection of this Skin disease.
C44.5	Skin of trunk	Skin	(●)	(●)	(●)	See the Skin chapter of the COSD User Guide (Overview Section) for further information on the collection of this Skin disease.
C44.6	Skin of upper limb, including shoulder	Skin	(●)	(●)	(●)	See the Skin chapter of the COSD User Guide (Overview Section) for further information on the collection of this Skin disease.
C44.7	Skin of lower limb, including hip	Skin	(●)	(●)	(●)	See the Skin chapter of the COSD User Guide (Overview Section) for further information on the collection of this Skin disease.

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C44.8	Overlapping lesion of skin	Skin	(●)	(●)	(●)	See the Skin chapter of the COSD User Guide (Overview Section) for further information on the collection of this Skin disease.
C44.9	Malignant neoplasm of skin, unspecified	Skin	(●)	(●)	(●)	See the Skin chapter of the COSD User Guide (Overview Section) for further information on the collection of this Skin disease.
C45.0	Mesothelioma of pleura	Lung	●			
C45.1	Mesothelioma of peritoneum	Lung	●			
C45.2	Mesothelioma of pericardium	Lung	●			
C45.7	Mesothelioma of other sites	Lung	●			
C45.9	Mesothelioma, unspecified	Lung	●			
C46.0	Kaposi sarcoma of skin	Sarcoma		●		
C46.1	Kaposi sarcoma of soft tissue	Sarcoma		●		
C46.2	Kaposi sarcoma of palate	Sarcoma		●		
C46.3	Kaposi sarcoma of lymph nodes	Sarcoma		●		
C46.7	Kaposi sarcoma of other sites	Sarcoma		●		
C46.8	Kaposi sarcoma of multiple organs	Sarcoma		●		
C46.9	Kaposi sarcoma, unspecified	Sarcoma		●		

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C47.0	*Peripheral nerves of head, face and neck*	*Brain/Central Nervous System*		●		*Usually treated by Sarcoma MDT.*
C47.1	*Peripheral nerves of upper limb, including shoulder*	*Brain/Central Nervous System*		●		*Usually treated by Sarcoma MDT.*
C47.2	*Peripheral nerves of lower limb, including hip*	*Brain/Central Nervous System*		●		*Usually treated by Sarcoma MDT.*
C47.3	*Peripheral nerves of thorax*	*Brain/Central Nervous System*		●		*Usually treated by Sarcoma MDT.*
C47.4	*Peripheral nerves of abdomen*	*Brain/Central Nervous System*		●		*Usually treated by Sarcoma MDT.*
C47.5	*Peripheral nerves of pelvis*	*Brain/Central Nervous System*		●		*Usually treated by Sarcoma MDT.*
C47.6	*Peripheral nerves of trunk, unspecified*	*Brain/Central Nervous System*		●		*Usually treated by Sarcoma MDT.*
C47.8	*Overlapping lesion of peripheral nerves and autonomic nervous system*	*Brain/Central Nervous System*		●		*Usually treated by Sarcoma MDT.*
C47.9	*Peripheral nerves and autonomic nervous system, unspecified*	*Brain/Central Nervous System*		●		*Usually treated by Sarcoma MDT.*
C48.0	*Retroperitoneum*	*Sarcoma*	●			*Usually treated by Sarcoma MDT.*
C48.1	*Specified parts of peritoneum*	*Sarcoma*	● *			** Sarcoma and Gynaecology Datasets to be collected where applicable.*

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C48.2	*Peritoneum, unspecified*	*Sarcoma*	● *			** Sarcoma and Gynaecology Datasets to be collected where applicable.*
C48.8	Overlapping lesion of retroperitoneum and peritoneum	Sarcoma	●			
C49.0	Connective and soft tissue of head, face and neck	Sarcoma	●			
C49.1	Connective and soft tissue of upper limb, including shoulder	Sarcoma	●			
C49.2	Connective and soft tissue of lower limb, including hip	Sarcoma	●			
C49.3	Connective and soft tissue of thorax	Sarcoma	●			
C49.4	Connective and soft tissue of abdomen	Sarcoma	●			
C49.5	Connective and soft tissue of pelvis	Sarcoma	●			
C49.6	Connective and soft tissue of trunk, unspecified	Sarcoma	●			
C49.8	Overlapping lesion of connective and soft tissue	Sarcoma	●			
C49.9	Connective and soft tissue, unspecified	Sarcoma	●			
C50.0	Nipple and areola	Breast	●			
C50.1	Central portion of breast	Breast	●			
C50.2	Upper-inner quadrant of breast	Breast	●			
C50.3	Lower-inner quadrant of breast	Breast	●			
C50.4	Upper-outer quadrant of breast	Breast	●			
C50.5	Lower-outer quadrant of breast	Breast	●			
C50.6	Axillary tail of breast	Breast	●			
C50.8	Overlapping lesion of breast	Breast	●			
C50.9	Breast, unspecified	Breast	●			

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C51.0	*Labium majus*	*Gynaecological*	● *			* *Gynaecology and Skin Datasets to be collected where applicable.*
C51.1	*Labium minus*	*Gynaecological*	● *			* *Gynaecology and Skin Datasets to be collected where applicable.*
C51.2	*Clitoris*	*Gynaecological*	● *			* *Gynaecology and Skin Datasets to be collected where applicable.*
C51.8	*Overlapping lesion of vulva*	*Gynaecological*	● *			* *Gynaecology and Skin Datasets to be collected where applicable.*
C51.9	*Vulva, unspecified*	*Gynaecological*	● *			* *Gynaecology and Skin Datasets to be collected where applicable.*
C52	Malignant neoplasm of vagina	Gynaecological	●			
C53.0	Endocervix	Gynaecological	●			
C53.1	Exocervix	Gynaecological	●			
C53.8	Overlapping lesion of cervix uteri	Gynaecological	●			
C53.9	Cervix uteri, unspecified	Gynaecological	●			
C54.0	Isthmus uteri	Gynaecological	●			
C54.1	Endometrium	Gynaecological	●			
C54.2	Myometrium	Gynaecological	●			
C54.3	Fundus uteri	Gynaecological	●			

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C54.8	Overlapping lesion of corpus uteri	Gynaecological	●			
C54.9	Corpus uteri, unspecified	Gynaecological	●			
C55	Malignant neoplasm of uterus, part unspecified	Gynaecological	●			
C56	Malignant neoplasm of ovary	Gynaecological	●			
C57.0	Fallopian tube	Gynaecological	●			
C57.1	Broad ligament	Gynaecological	●			
C57.2	Round ligament	Gynaecological	●			
C57.3	Parametrium	Gynaecological	●			
C57.4	Uterine adnexa, unspecified	Gynaecological	●			
C57.7	Other specified female genital organs	Gynaecological	●			
C57.8	Overlapping lesion of female genital organs	Gynaecological	●			
C57.9	Female genital organ, unspecified	Gynaecological	●			
C58	Malignant neoplasm of placenta	Gynaecological	●			
C60.0	*Prepuce*	*Urological*	● *			** Urology and Skin Datasets to be collected where applicable.*
C60.1	*Glans penis*	*Urological*	● *			** Urology and Skin Datasets to be collected where applicable.*
C60.2	*Body of penis*	*Urological*	● *			** Urology and Skin Datasets to be collected where applicable.*
C60.8	*Overlapping lesion of penis*	*Urological*	● *			** Urology and Skin Datasets to be collected where applicable.*

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C60.9	*Penis, unspecified*	*Urological*	● *			** Urology and Skin Datasets to be collected where applicable.*
C61	Malignant neoplasm of prostate	Urological	●			
C62.0	Undescended testis	Urological	●			
C62.1	Descended testis	Urological	●			
C62.9	Testis, unspecified	Urological	●			
C63.0	Epididymis	Urological	●			
C63.1	Spermatic cord	Urological	●			
C63.2	Scrotum	Urological		●		
C63.7	Other specified male genital organs	Urological	●			
C63.8	Overlapping lesion of male genital organs	Urological	●			
C63.9	Male genital organ, unspecified	Urological	●			
C64	Malignant neoplasm of kidney, except renal pelvis	Urological	●			
C65	Malignant neoplasm of renal pelvis	Urological	●			
C66	Malignant neoplasm of ureter	Urological	●			
C67.0	Trigone of bladder	Urological	●			
C67.1	Dome of bladder	Urological	●			
C67.2	Lateral wall of bladder	Urological	●			
C67.3	Anterior wall of bladder	Urological	●			
C67.4	Posterior wall of bladder	Urological	●			
C67.5	Bladder neck	Urological	●			
C67.6	Ureteric orifice	Urological	●			
C67.7	Urachus	Urological	●			
C67.8	Overlapping lesion of bladder	Urological	●			
C67.9	Bladder, unspecified	Urological	●			
C68.0	Urethra	Urological	●			
C68.1	Paraurethral glands	Urological	●			

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C68.8	Overlapping lesion of urinary organs	Urological	●			
C68.9	Urinary organ, unspecified	Urological	●			
C69.0	*Conjunctiva*	*Brain/Central Nervous System*		●		*Not normally treated by CNS MDT.*
C69.1	*Cornea*	*Brain/Central Nervous System*		●		*Not normally treated by CNS MDT.*
C69.2	*Retina*	*Brain/Central Nervous System*		●		*Not normally treated by CNS MDT.*
C69.3	*Choroid*	*Brain/Central Nervous System*		●		*Not normally treated by CNS MDT.*
C69.4	*Ciliary body*	*Brain/Central Nervous System*		●		*Not normally treated by CNS MDT.*
C69.5	*Lachrymal gland and duct*	*Brain/Central Nervous System*		●		*Not normally treated by CNS MDT.*
C69.6	*Orbit*	*Brain/Central Nervous System*		●		*Not normally treated by CNS MDT. Maybe treated by Sarcoma MDT.*
C69.8	*Overlapping lesion of eye and adnexa*	*Brain/Central Nervous System*		●		*Not normally treated by CNS MDT.*
C69.9	*Eye, unspecified*	*Brain/Central Nervous System*		●		*Not normally treated by CNS MDT.*
C70.0	Cerebral meninges	Brain/Central Nervous System	●			
C70.1	Spinal meninges	Brain/Central Nervous System	●			
C70.9	Meninges, unspecified	Brain/Central Nervous System	●			
C71.0	Cerebrum, except lobes and ventricles	Brain/Central Nervous System	●			
C71.1	Frontal lobe	Brain/Central Nervous System	●			
C71.2	Temporal lobe	Brain/Central Nervous System	●			
C71.3	Parietal lobe	Brain/Central Nervous System	●			

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C71.4	Occipital lobe	Brain/Central Nervous System	●			
C71.5	Cerebral ventricle	Brain/Central Nervous System	●			
C71.6	Cerebellum	Brain/Central Nervous System	(●) (*)			CTYA dataset collected for Meduloblast oma patients under 25.
C71.7	Brain stem	Brain/Central Nervous System	●			
C71.8	Overlapping lesion of brain	Brain/Central Nervous System	●			
C71.9	Brain, unspecified	Brain/Central Nervous System	●			
C72.0	Spinal cord	Brain/Central Nervous System	●			
C72.1	Cauda equina	Brain/Central Nervous System	●			
C72.2	Olfactory nerve	Brain/Central Nervous System	●			
C72.3	Optic nerve	Brain/Central Nervous System	●			
C72.4	Acoustic nerve	Brain/Central Nervous System	●			
C72.5	Other and unspecified cranial nerves	Brain/Central Nervous System	●			
C72.8	Overlapping lesion of brain and other parts of central nervous system	Brain/Central Nervous System	●			
C72.9	Central nervous system, unspecified	Brain/Central Nervous System	●			
C73	Malignant neoplasm of thyroid gland	Head and Neck		●		
C74.0	Cortex of adrenal gland	Other		●		
C74.1	Medulla of adrenal gland	Other		●		
C74.9	Adrenal gland, unspecified	Other		●		
C75.0	Parathyroid gland	Other		●		
C75.1	*Pituitary gland*	*Other*	*			*Usually treated by CNS MDT.*
C75.2	*Craniopharyngeal duct*	*Other*	*			*Usually treated by CNS MDT.*

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C75.3	*Pineal gland*	*Other*	*			*Usually treated by CNS MDT.*
C75.4	Carotid body	Other		●		
C75.5	Aortic body and other paraganglia	Other		●		
C75.8	Pluriglandular involvement, unspecified	Other		●		
C75.9	Endocrine gland, unspecified	Other		●		
C76.0	Head, face and neck	Other		●		Other and ill defined - use only if unable to code to specific primary site
C76.1	Thorax	Other		●		Other and ill defined - use only if unable to code to specific primary site
C76.2	Abdomen	Other		●		Other and ill defined - use only if unable to code to specific primary site
C76.3	Pelvis	Other		●		Other and ill defined - use only if unable to code to specific primary site
C76.4	Upper limb	Other		●		Other and ill defined - use only if unable to code to specific primary site
C76.5	Lower limb	Other		●		Other and ill defined - use only if unable to code to specific primary site

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C76.7	Other ill-defined sites	Other		●		Other and ill defined - use only if unable to code to specific primary site
C76.8	Overlapping lesion of other and ill-defined sites	Other		●		Other and ill defined - use only if unable to code to specific primary site
C77.0	Lymph nodes of head, face and neck	Head and Neck	●			Secondary - only use if unable to code to specific primary site
C77.1	Intrathoracic lymph nodes	Other		●		Secondary - only use if unable to code to specific primary site
C77.2	Intra-abdominal lymph nodes	Other		●		Secondary - only use if unable to code to specific primary site
C77.3	Axillary and upper limb lymph nodes	Other		●		Secondary - only use if unable to code to specific primary site
C77.4	Inguinal and lower limb lymph nodes	Other		●		Secondary - only use if unable to code to specific primary site
C77.5	Intrapelvic lymph nodes	Other		●		Secondary - only use if unable to code to specific primary site

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C77.8	Lymph nodes of multiple regions	Other		●		Secondary - only use if unable to code to specific primary site
C77.9	Lymph node, unspecified	Other		●		Secondary - only use if unable to code to specific primary site
C78.0	Secondary malignant neoplasm of lung	Lung		●		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
C78.1	Secondary malignant neoplasm of mediastinum	Lung		●		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
C78.2	Secondary malignant neoplasm of pleura	Lung		●		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
C78.3	Secondary malignant neoplasm of other and unspecified respiratory organs	Lung		●		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C78.4	Secondary malignant neoplasm of small intestine	Colorectal		●		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
C78.5	Secondary malignant neoplasm of large intestine and rectum	Colorectal		●		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
C78.6	Secondary malignant neoplasm of retroperitoneum and peritoneum	Sarcoma		●		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
C78.7	Secondary malignant neoplasm of liver and intrahepetic bile duct	Upper Gastrointestinal		●		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
C78.8	Secondary malignant neoplasm of other and unspecified digestive organs	Colorectal		●		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C79.0	Secondary malignant neoplasm of kidney and renal pelvis	Urological		●		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
C79.1	Secondary malignant neoplasm of bladder and other and unspecified urinary organs	Urological		●		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
C79.2	Secondary malignant neoplasm of skin	Skin		●		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
C79.3	Secondary malignant neoplasm of brain and cerebral meninges	Brain/Central Nervous System		●		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
C79.4	Secondary malignant neoplasm of other and unspecified parts of nervous system	Brain/Central Nervous System		●		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C79.5	Secondary malignant neoplasm of bone and bone marrow	Sarcoma		●		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
C79.6	Secondary malignant neoplasm of ovary	Gynaecological		●		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
C79.7	Secondary malignant neoplasm of adrenal gland	Other		●		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
C79.8	Secondary malignant neoplasm of other specified sites	Other		●		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
C79.9	Secondary malignant neoplasm, unspecified site	Other		●		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
C80.0	Malignant neoplasm, primary site unknown, so stated	Other		●		Only use if unable to code to specific primary site.

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C80.9	Malignant neoplasm, unspecified	Other		●		Only use if unable to code to specific primary site.
C81.0	Nodular lymphocyte predominant Hodgkin lymphoma	Haematological	See the Haematology chapter of COSD User Guide (Section 7.2) for information regarding what is required to be submitted for these Haematology diseases.			
C81.1	Nodular sclerosis classical Hodgkin lymphoma	Haematological				
C81.2	Mixed cellularity classical Hodgkin lymphoma	Haematological				
C81.3	Lymphocytic depleted classical Hodgkin lymphoma	Haematological				
C81.4	Lymphocyte-rich classical Hodgkin lymphoma	Haematological				
C81.7	Other classical Hodgkin lymphoma	Haematological				
C81.9	Hodgkin lymphoma, unspecified	Haematological				
C82.0	Follicular lymphoma grade i	Haematological				
C82.1	Follicular lymphoma grade ii	Haematological				
C82.2	Follicular lymphoma grade iii, unspecified	Haematological				
C82.3	Follicular lymphoma grade iiia	Haematological				
C82.4	Follicular lymphoma grade iiib	Haematological				
C82.5	Diffuse follicle centre lymphoma	Haematological				
C82.6	Cutaneous follicle centre lymphoma	Haematological				
C82.7	Other types of follicular lymphoma	Haematological				
C82.9	Follicular lymphoma, unspecified	Haematological				
C83.0	Small cell B-cell lymphoma	Haematological				
C83.1	Mantle cell lymphoma	Haematological				
C83.3	Diffuse large B-cell lymphoma	Haematological				

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C83.5	Lymphoblastic (diffuse) lymphoma	Haematological				
C83.7	Burkitt lymphoma	Haematological				
C83.8	Other non-follicular lymphoma	Haematological				
C83.9	Non-follicular (diffuse) lymphoma, unspecified	Haematological				
C84.0	Mycosis fungoides	Haematological				
C84.1	Sezéry disease	Haematological				
C84.4	Peripheral T-cell lymphoma, not elsewhere classified	Haematological				
C84.5	Other mature T/NK-cell lymphomas	Haematological				
C84.6	Anaplastic large cell lymphoma, ALK-positive	Haematological				
C84.7	Anaplastic large cell lymphoma, ALK-negative	Haematological				
C84.8	Cutaneous T-cell lymphoma, unspecified	Haematological				
C84.9	Mature T/NK-cell lymphoma, unspecified	Haematological				
C85.1	B-cell lymphoma, unspecified	Haematological				
C85.2	Mediastinal (thymic) large B-cell lymphoma	Haematological				
C85.7	Other specified types of non-Hodgkin lymphoma	Haematological				
C85.9	Non-Hodgkin lymphoma, unspecified	Haematological				
C86.0	Extranodal NK/T-cell lymphoma, nasal type	Haematological				
C86.1	Hepatosplenic T-cell lymphoma	Haematological				
C86.2	Enteropathy-type (intestinal) T-cell lymphoma	Haematological				
C86.3	Subcutaneous panniculitis-like T-cell lymphoma	Haematological				

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C86.4	Blastic N/K-cell lympthoma	Haematological				
C86.5	Angioimmunoblastic T-cell lymphoma	Haematological				
C86.6	Primary cutaneous CD30-positive T-cell proliferations	Haematological				
C88.0	Waldenström macroglobulinaemia	Haematological				
C88.2	Other heavy chain disease	Haematological				
C88.3	Immunoproliferative small intestinal disease	Haematological				
C88.4	Extranodal marginal zone B-cell lymphoma of mucosa associated lymphoid tissue (MALT-lymphoma)	Haematological				
C88.7	Other malignant immunoproliferative diseases	Haematological				
C88.9	Malignant immunoproliferative disease, unspecified	Haematological				
C90.0	Multiple myeloma	Haematological				
C90.1	Plasma cell leukaemia	Haematological				
C90.2	Extramedullary plasmacytoma	Haematological				
C90.3	Solitary plasmacytoma	Haematological				
C91.0	Acute lymphoblastic leukaemia [ALL]	Haematological				
C91.1	Chronic lymphocytic leukaemia of B-cell type	Haematological				
C91.3	Prolymphocytic leukaemia of B-cell type	Haematological				
C91.4	Hairy-cell leukaemia	Haematological				
C91.5	Adult T-cell lymphoma/leukaemia (HTLV-1-associated)	Haematological				
C91.6	Prolymphocytic leukaemia of T-cell type	Haematological				

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C91.7	Other lymphoid leukaemia	Haematological				
C91.8	Mature B-cell leukaemia Burkitt-type	Haematological				
C91.9	Lymphoid leukaemia, unspecified	Haematological				
C92.0	Acute myeloid leukaemia [AML]	Haematological				
C92.1	Chronic myeloid leukaemia [CML], BCR/ABL-positive	Haematological				
C92.2	Atypical chronic myeloid leukaemia, BCR/ABL-negative	Haematological				
C92.3	Myeloid sarcoma	Haematological				
C92.4	Acute promyelocytic leukaemia [PML]	Haematological				
C92.5	Acute myelomonocytic leukaemia	Haematological				
C92.6	Acute myeloid leukaemia with 11q23-abnormality	Haematological				
C92.7	Other myeloid leukaemia	Haematological				
C92.8	Acute myeloid leukaemia with multilineage dysplasia	Haematological				
C92.9	Myeloid leukaemia, unspecified	Haematological				
C93.0	Acute monoblastic/monocytic leukaemia	Haematological				
C93.1	Chronic myelomonocytic leukaemia	Haematological				
C93.3	Juvenile myelomonocytic leukaemia	Haematological				
C93.7	Other monocytic leukaemia	Haematological				
C93.9	Monocytic leukaemia, unspecified	Haematological				
C94.0	Acute erythroid leukaemia	Haematological				

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C94.2	Acute megakaryoblastic leukaemia	Haematological				
C94.3	Mast cell leukaemia	Haematological				
C94.4	Acute panmyelosis with myelofibrosis	Haematological				
C94.6	Myelodysplastic and myeloproliferative disease, not elsewhere classified	Haematological				
C94.7	Other specified leukaemias	Haematological				
C95.0	Acute leukaemia of unspecified cell type	Haematological				
C95.1	Chronic leukaemia of unspecified cell type	Haematological				
C95.7	Other leukaemia of unspecified cell type	Haematological				
C95.9	Leukaemia, unspecified	Haematological				
C96.0	Multifocal and multisystemic (disseminated) Langerhans-cell histiocytosis [Letterer-Siwe disease]	Haematological				
C96.2	Malignant mast cell tumour	Haematological				
C96.4	Sarcoma of dendritic cells (accessory cells)	Haematological				
C96.5	Multifocal and unisystemic (disseminated) Langerhans-cell histiocytosis	Haematological				
C96.6	Unifocal Langerhans-cell histiocytosis	Haematological				
C96.7	Other specified malignant neoplasms of lymphoid, haematopoietic and related tissue	Haematological				
C96.8	Histiocytic sarcoma	Haematological				
C96.9	Malignant neoplasms of lymphoid, haematopoietic and related tissue, unspecified	Haematological				

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C97	Malignant neoplasms of independent (primary) multiple sites	Other		●		
D05.0	Lobular carcinoma in situ	Breast	●			
D05.1	Intraductal carcinoma in situ	Breast	●			
D05.7	Other carcinoma in situ of breast	Breast	●			
D05.9	Carcinoma in situ of breast, unspecified	Breast	●			

APPENDIX B – MANDATORY REGISTERABLE CONDITIONS

MANDATORY REGISTERABLE CONDITIONS (from the UKACR Library of Recommendations)

Further details to be provided regarding applicable data fields for each disease

Notes:

The following table lists all the registerable diseases by ICD10 code, together with the expected dataset to be completed and the potential stage.
This table provides general guidelines only as not all permutations can be covered and there will always be exceptions. Local clinical input is essential to identify and complete the appropriate stage.
Further guidance is available from your local cancer registration service office.

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C00.0 – C97	Malignant neoplasms (See Appendix A for full list)					
D00.0	Carcinoma in situ of Lip, oral cavity and pharynx	Head and Neck			●	
D00.1	Carcinoma in situ of Oesophagus	Upper Gastrointestinal			●	
D00.2	Carcinoma in situ of Stomach	Upper Gastrointestinal			●	
D01.0	Carcinoma in situ of Colon	Colorectal			●	
D01.1	Carcinoma in situ of Rectosigmoid junction	Colorectal			●	
D01.2	Carcinoma in situ of Rectum	Colorectal			●	
D01.3	Carcinoma in situ of Anus and anal canal	Colorectal			●	
D01.4	Carcinoma in situ of Anus and anal canal	Colorectal			●	
D01.5	Carcinoma in situ of Liver, gallbladder and bile ducts	Upper Gastrointestinal			●	
D01.7	Other specified digestive organs	Colorectal			●	
D01.9	Carcinoma in situ of Digestive organ, unspecified	Colorectal			●	
D02.0	Carcinoma in situ of Larynx	Head and Neck			●	

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
D02.1	Carcinoma in situ of Trachea	Lung			●	
D02.2	Carcinoma in situ of Bronchus and lung	Lung			●	
D02.3	Carcinoma in situ of Other parts of respiratory system	Lung			●	
D02.4	Carcinoma in situ of Respiratory system, unspecified	Lung			●	
D03.0	Melanoma in situ of lip	Skin	●			
D03.1	Melanoma in situ of eyelid, including canthus	Skin	●			
D03.2	Melanoma in situ, of ear and external auricular canal	Skin	●			
D03.3	Melanoma in situ of other and unspecified parts of face	Skin	●			
D03.4	Melanoma in situ of scalp and neck	Skin	●			
D03.5	Melanoma in situ of trunk	Skin	●			
D03.6	Melanoma in situ of upper limb, including shoulder	Skin	●			
D03.7	Melanoma in situ of lower limb, including hip	Skin	●			
D03.8	Melanoma in situ of other sites	Other			●	
D03.9	Melanoma in situ, unspecified	Skin	●			
D04.0	Carcinoma in situ of skin of lip	Skin			●	
D04.1	Carcinoma in situ of skin of eyelid, including canthus	Skin			●	
D04.2	Carcinoma in situ of skin of ear and external auricular canal	Skin			●	

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
D04.3	Carcinoma in situ of skin of other and unspecified parts of face	Skin			●	
D04.4	Carcinoma in situ of skin of scalp and neck	Skin			●	
D04.5	Carcinoma in situ of skin of trunk	Skin			●	
D04.6	Carcinoma in situ of skin of upper limb, including shoulder	Skin			●	
D04.7	Carcinoma in situ of skin of lower limb, including hip	Skin			●	
D04.8	Carcinoma in situ of skin of other sites	Skin			●	
D04.9	Carcinoma in situ of skin, unspecified	Skin			●	
D05.0	Lobular carcinoma in situ	Breast	●			
D05.1	Intraductal carcinoma in situ	Breast	●			
D05.7	Other carcinoma in situ of breast	Breast	●			
D05.9	Carcinoma in situ of breast, unspecified	Breast	●			
D06.0	carcinoma in situ of endocervix	Gynaecological			●	
D06.1	carcinoma in situ of exocervix	Gynaecological			●	
D06.7	carcinoma in situ of other parts of cervix	Gynaecological			●	
D06.9	carcinoma in situ of cervix, unspecified	Gynaecological			●	
D07.0	carcinoma in situ of endometrium	Gynaecological			●	
D07.1	carcinoma in situ of vulva	Gynaecological			●	
D07.2	carcinoma in situ of vagina	Gynaecological			●	

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
D07.3	carcinoma in situ of other and unspecified female genital organs	Gynaecological			●	
D07.4	carcinoma in situ of penis	Urological			●	
D07.5	carcinoma in situ of prostate	Urological			●	
D07.6	carcinoma in situ of other and unspecified male genital organs	Urological			●	
D09.0	Carcinoma in situ of Bladder	Urological	●			
D09.1	carcinoma in situ of other and unspecified urinary organs	Urological			●	
D09.2	carcinoma in situ of eye	Other			●	
D09.3	carcinoma in situ of thyroid and other endocrine glands	Head and Neck			●	
D09.7	carcinoma in situ of other specified sites	Other			●	
D09.9	carcinoma in situ, unspecified	Other			●	
D32.0	benign neoplasm of cerebral meninges	Brain/Central Nervous System	●			
D32.1	benign neoplasm of spinal meninges	Brain/Central Nervous System	●			
D32.9	benign neoplasm of meninges, unspecified	Brain/Central Nervous System	●			
D33.0	Benign neoplasm of brain, supratentorial	Brain/Central Nervous System	●			
D33.1	Benign neoplasm of brain, infratentorial	Brain/Central Nervous System	●			
D33.2	Benign neoplasm of brain, unspecified	Brain/Central Nervous System	●			
D33.3	Benign neoplasm of cranial nerves	Brain/Central Nervous System	●			

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
D33.4	Benign neoplasm of spinal cord	Brain/Central Nervous System	●			
D33.7	Benign neoplasm of other specified parts of central nervous system	Brain/Central Nervous System	●			
D33.9	Benign neoplasm of central nervous system, unspecified	Brain/Central Nervous System	●			
D35.2	Benign neoplasm of Pituitary gland	Brain/Central Nervous System	●			
D35.3	*Benign neoplasm of Craniopharyngeal duct*	*Other*	●			*Usually classified as CNS*
D35.4	Benign neoplasm of Pineal gland	Brain/Central Nervous System	●			
D37.0	Neoplasm of uncertain or unknown behaviour of lip, oral cavity and pharynx	Head and Neck			●	
D37.1	Neoplasm of uncertain or unknown behaviour of Stomach	Upper Gastrointestinal			●	
D37.2	Neoplasm of uncertain or unknown behaviour of Small intestine	Upper Gastrointestinal			●	
D37.3	Neoplasm of uncertain or unknown behaviour of Appendix	Colorectal			●	
D37.4	Neoplasm of uncertain or unknown behaviour of Colon	Colorectal			●	
D37.5	Neoplasm of uncertain or unknown behaviour of Rectum	Colorectal			●	

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
D37.6	Liver, gallbladder and bile ducts	Upper Gastrointestinal			●	
D37.7	Other digestive organs	Colorectal/Upper Gastrointestinal			●	
D37.9	Digestive organ, unspecified	Colorectal/Upper Gastrointestinal			●	
D38.0	Neoplasm of uncertain or unknown behaviour of Larynx	Head and Neck			●	
D38.1	Neoplasm of uncertain or unknown behaviour of Trachea, bronchus and lung	Lung			●	
D38.2	Neoplasm of uncertain or unknown behaviour of Pleura	Lung			●	
D38.3	Neoplasm of uncertain or unknown behaviour of Mediastinum	Lung			●	
D38.4	Neoplasm of uncertain or unknown behaviour of Thymus	Lung			●	
D38.5	Neoplasm of uncertain or unknown behaviour of Other respiratory organs	Lung			●	
D38.6	Neoplasm of uncertain or unknown behaviour of Respiratory organ, unspecified	Lung			●	
D39.0	Neoplasm of uncertain or unknown behaviour of Uterus	Gynaecological			●	

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
D39.1	Neoplasm of uncertain or unknown behaviour of Ovary	Gynaecological			●	
D39.2	Neoplasm of uncertain or unknown behaviour of Placenta	Gynaecological			●	
D39.7	Neoplasm of uncertain or unknown behaviour of Other female genital organs	Gynaecological			●	
D39.9	Neoplasm of uncertain or unknown behaviour of Female genital organ, unspecified	Gynaecological			●	
D40.0	Neoplasm of uncertain or unknown behaviour of prostate	Urological			●	
D40.1	Neoplasm of uncertain or unknown behaviour of testis	Urological			●	
D40.7	Neoplasm of uncertain or unknown behaviour of other male genital organs	Urological			●	
D40.9	Neoplasm of uncertain or unknown behaviour of male genital organs, unspecifed	Urological			●	
D41.0	Neoplasm of uncertain or unknown behaviour of kidney	Urological			●	

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
D41.1	Neoplasm of uncertain or unknown behaviour of renal pelvis	Urological	●			
D41.2	Neoplasm of uncertain or unknown behaviour of ureter	Urological	●			
D41.3	Neoplasm of uncertain or unknown behaviour of urethra	Urological	●			
D41.4	Neoplasm of uncertain or unknown behaviour of bladder	Urological	●			
D41.7	Neoplasm of uncertain or unknown behaviour of other urinary organs	Urological			●	
D41.9	Neoplasm of uncertain or unknown behaviour of urinary organs, unspecified	Urological			●	
D42.0	Neoplasm of uncertain or unknown behaviour of cerebral meninges	Brain/Central Nervous System	●			
D42.1	Neoplasm of uncertain or unknown behaviour of spinal meninges	Brain/Central Nervous System	●			
D42.9	Neoplasm of uncertain or unknown behaviour of meninges, unspecified	Brain/Central Nervous System	●			

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
D43.0	Neoplasm of uncertain or unknown behaviour of brain, supratentorial	Brain/Central Nervous System	●			
D43.1	Neoplasm of uncertain or unknown behaviour of brain, infratentorial	Brain/Central Nervous System	●			
D43.2	Neoplasm of uncertain or unknown behaviour of brain, unspecified	Brain/Central Nervous System	●			
D43.3	Neoplasm of uncertain or unknown behaviour of cranial nerves	Brain/Central Nervous System	●			
D43.4	Neoplasm of uncertain or unknown behaviour of spinal cord	Brain/Central Nervous System	●			
D43.7	Neoplasm of uncertain or unknown behaviour of other parts of central nervous system	Brain/Central Nervous System	●			
D43.9	Neoplasm of uncertain or unknown behaviour of central nervous system, unspecified	Brain/Central Nervous System	●			
D44.0	Neoplasm of uncertain or unknown behaviour of thyroid gland	Head and Neck			●	
D44.1	Neoplasm of uncertain or unknown behaviour of adrenal gland	Other			●	

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
D44.2	Neoplasm of uncertain or unknown behaviour of parathyroid gland	Other			●	
D44.3	Neoplasm of uncertain or unknown behaviour of pituitary gland	Brain/Central Nervous System	●			
D44.4	Neoplasm of uncertain or unknown behaviour of Craniopharyngeal duct	Brain/Central Nervous System	●			
D44 .5	Neoplasm of uncertain or unknown behaviour of pineal gland	Brain/Central Nervous System	●			
D44 .6	Neoplasm of uncertain or unknown behaviour of carotid body	Other			●	
D44 .7	Neoplasm of uncertain or unknown behaviour of aortic body and other paraganglia body	Other			●	
D44 .8	Neoplasm of uncertain or unknown behaviour of pluriglandular involvement	Other			●	
D44 .9	Neoplasm of uncertain or unknown behaviour of endocrine gland, unspecified	Other			●	
D45	Polycythaemia vera	Haematological	See the Haematology chapter of COSD User Guide (Section 7.2) for information regarding			

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
D46.0	Refractory anaemia without ringed sideroblasts, so stated	Haematological	what is required to be submitted for these Haematology diseases.			
D46.1	Refractory anaemia with ringed sideroblasts	Haematological				
D46.2	Refractory anaemia with excess of blasts	Haematological				
D46.4	Refractory anaemia, unspecified	Haematological				
D46.5	Refractory anaemia with multi-lineage dysplasia	Haematological				
D46.6	Myelodysplastic syndrome with isolated del(5q) chromosomal abnormality	Haematological				
D46.7	Other myelodysplastic syndromes	Haematological				
D46.9	Myelodysplastic syndrome, unspecified	Haematological				
D47.0	Histiocytic and mast cell tumours of uncertain and unknown behaviour	Haematological				
D47.1	Chronic myeloproliferative disease	Haematological				
D47.3	Essential (haemorrhagic) thrombocythaemia	Haematological				
D47.4	Osteomyelofibrosis	Haematological				
D47.5	Chronic eosinophilic leukamia (hypereosinophilic syndrome)	Haematological				

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
D47.7	Other specified neoplasms of uncertain or unknown behaviour of lymphoid, haematopoietic and related tissue	Haematological				
D47.9	Neoplasm of uncertain or unknown behaviour of lymphoid, haematopoietic and related tissue, unspecified	Haematological				
D48.0	Neoplasm of uncertain or unknown behaviour of Bone and articular cartilage	Sarcoma			●	
D48.1	Neoplasm of uncertain or unknown behaviour of Connective and other soft tissue	Sarcoma			●	Only applicable for GISTs
D48.2	Neoplasm of uncertain or unknown behaviour of Peripheral nerves and autonomic nervous system	Other			●	
D48.3	Neoplasm of uncertain or unknown behaviour of Retroperitoneum	Other			●	
D48.4	Neoplasm of uncertain or unknown behaviour of Peritoneum	Other			●	
D48.5	Neoplasm of uncertain or unknown behaviour of Skin	Skin			●	

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
D48.6	Neoplasm of uncertain or unknown behaviour of Breast	Breast			●	
D48.7	Neoplasm of uncertain or unknown behaviour of Other specified sites	Other			●	
D48.9	Neoplasm of uncertain or unknown behaviour unspecified	Other			●	
E85.9[15]	Amyloidosis, unspecified	Haematology	See the Haematology chapter of COSD User Guide (Section 7.2) for information regarding what is required to be submitted for these Haematology diseases.			

[15] Although Primary amyloidosis (E85.9) is listed as an E ICD code in the World Health Organisation (WHO) disease classification, amongst clinicians it is widely acknowledged and subsequently treated as a cancer, receiving Chemotherapy in cases. Whilst we await the WHO disease classification being updated to reflect this fact, we are proposing extending the scope of the COSD to include this. The United Kingdom and Ireland Association of Cancer Registries (UKIACR) is currently considering its inclusion in the UKIACR Library of Recommendations.

APPENDIX C – WHO CLASSIFICATION OF TUMOURS OF HAEMATOPOETIC AND LYMPHOID TISSUE

Group numbers have been assigned for ease of reference as used in Section 7.2 ICD Codes and WHO Disease Groups in the Haematology section of the User Guide. (WHO Classification does not distinguish Groups 7 & 8 as separate disease groups)

GROUP #	Description
GROUP 1	*Myeloproliferative neoplasms*
GROUP 2	*Myeloid and lymphoid neoplasms with eosinophilia and abnormalities of PDGFRA, PDGFRB or FGFR1*
GROUP 3	*Myelodysplastic/myeloproliferative neoplasms*
GROUP 4	*Myelodysplastic syndromes*
GROUP 5	*Acute myeloid leukaemia (AML) and related Precursor neoplasms*
GROUP 6	*Acute leukaemias of ambiguous lineage*
GROUP 7	*Precursor B lymphoid neoplasms*
GROUP 8	*Precursor T lymphoid neoplasms*
GROUP 9	*Mature B cell neoplasms*
GROUP 10	*Mature T-cell and NK-cell neoplasms*
GROUP 11	*Hodgkin lymphoma*
GROUP 12	*Histiocytic and dendritic cell neoplasm*
GROUP 13	*Post-transplant lymphoproliferative disorders (PTLD)*

APPENDIX D – CTYA – ASSOCIATED CONDITIONS

Associated Conditions to be recorded on Childhood Cancer Registration Forms

The associated conditions in the patient should include any medical condition that could be related to aetiology of the child's cancer or could affect treatment or outcome. The main categories that are likely to be of interest and should therefore be recorded are as follows, listed by Chapter within ICD-10.

ICD10 Chapter	ICD 10 Codes	Conditions	Examples
I	B15-B19	Viral hepatitis	
	B20-B24	HIV disease	
II	C00-C97	Malignant neoplasms	Any malignancy diagnosed before the subject of the current registration
	D00-D48	Benign and unspecified neoplasms	Melanocytivc naevus, neurofibroma
III	D50-D98	Diseases of blood, blood-forming organs & immune system	Thalassaemia, sickle-cell disease or trait, spherocytosis,Diamond-Blackfan anaemia, Fanconi anaemia,aplastic anaemia, Von Willebrand disease, severe combined immune deficiency, Wiskott-Aldrich syndrome
IV	E00-E90	Endocrine, nutritional & metabolic diseases	Goitre, diabetes, congenital adrenal hyperplasia, albinism, cystic fibrosis
V	F70-F79	Mental retardation	
	F80-F89	Disorders of psychological development	Autism
	F90-F98	Early-onset behavioural & emotional disorders	Attention deficit hyperactivity disorder
VI	G11	Hereditary ataxia	Ataxia telangiectasia
	G25.3	Opsoclonus-myoclonus	
	G40	Epilepsy	
	G51.0	Bell's palsy	
	G71.0	Muscular dystrophy	
	G90	Autonomic nervous system disorders	Horner syndrome
VII	H50	Strabismus	

ICD10 Chapter	ICD 10 Codes	Conditions	Examples
XI	K40	Inguinal hernia	
XII	L20-L30	Dermatitis & eczema	
	L81.3	Café au lait spots	
XIII	M08	Juvenile arthritis	
XVI	P00-P96	Conditions originating in perinatal period	Extreme prematurity, birth asphyxia, congenital rubella syndrome, neonatal jaundice, congenital hydrocele
XVII	Q00-Q89	Congenital malformations	Coloboma, aniridia, cardiac defects, cleft lip or palate, Hirschsprung disease, cryptorchism, hypospadias, (pseudo-)hermaphroditism, congenital malformations of kidney, neurofibromatosis, tuberous sclerosis, hemihypertrophy, Beckwith-Wiedmann syndrome
	Q90-Q99	Constitutional chromosomal abnormalities	Down syndrome, Turner syndrome, Klinefelter syndrome, gonadal dysgenesis, fragile X chromosome
XVIII	R01	Heart murmur	
	R62	Developmental delay	

The list given above is not meant to be exhaustive. Where examples are given, these are simply the most frequent or important conditions within a given category. The overriding rule should be that, if it is believed that a condition might be relevant to aetiology, produce significant comorbidity, or otherwise affect treatment or prognosis, and then it should be recorded.

In particular, it is suggested that any heritable condition included in *Online Mendelian Inheritance in Man (OMIM)*, http://www.ncbi.nlm.nih.gov/omim, should be recorded.

APPENDIX E – RECOMMENDED STAGING TO BE COLLECTED BY CANCER REGISTRIES

The National Staging Panel for Cancer Registration recommends that the staging systems recorded by the cancer registries follow the guidance issued by the Royal College of Pathologists and the Cancer Outcomes Services Dataset:

TUMOUR TYPE	***STAGING SYSTEM***
ADRENAL CORTEX TUMOURS	UICC TNM 7
AMPULLA OF VATER - CARCINOMA	UICC TNM 7
AMPULLA OF VATER - NEUROENDOCRINE TUMOURS	EUROPEAN NEUROENDOCRINE TUMOUR SOCIETY TNM***
ANAL CANAL	UICC TNM 7
APPENDIX - CARCINOMA	UICC TNM 7
APPENDIX - NEUROENDOCRINE TUMOURS	EUROPEAN NEUROENDOCRINE TUMOUR SOCIETY TNM***
BONE	UICC TNM 7
BREAST	UICC TNM 7
CERVIX	FIGO AND N STAGE
CHRONIC LYMPHOCYTIC LEUKAEMIA	RAI AND BINET
COLON AND RECTUM - CARCINOMA	UICC TNM 5 & DUKES
COLON AND RECTUM – GIST	UICC TNM 7
COLON AND RECTUM - NEUROENDOCRINE TUMOURS	EUROPEAN NEUROENDOCRINE TUMOUR SOCIETY TNM***
CONJUNCTIVA - CARCINOMA	UICC TNM 7
CONJUNCTIVA – MELANOMA	UICC TNM 7
CUTANEOUS SQUAMOUS CELL CARCINOMA AND OTHER CUTANEOUS CARCINOMA	AJCC TNM 7
EXTRAHEPATIC BILE DUCT - PERIHILAR	UICC TNM 7
EXTRAHEPATIC BILE DUCTS - DISTAL	UICC TNM 7
FALLOPIAN TUBE	FIGO
GALLBLADDER	UICC TNM 7
GLOTTIS	UICC TNM 7
HODGKINS LYMPHOMA	ANN-ARBOR
HYPOPHARYNX	UICC TNM 7
KIDNEY	UICC TNM 7*
KIDNEY, WILMS	WILMS TUMOUR STAGE (NWTSG)
LACRIMAL GLAND - CARCINOMA	UICC TNM 7
LIP	UICC TNM 7
LIVER - INTRAHEPATIC BILE DUCTS	UICC TNM 7
LIVER - HEPATOCELLULAR	UICC TNM 7
LUNG	UICC TNM 7
MAJOR SALIVARY GLANDS	UICC TNM 7
MAXILLARY SINUS	UICC TNM 7
MEDULLOBLASTOMA	CHANG STAGING SYSTEM
MYELOMA	INTERNATIONAL STAGING SYSTEM (ISS)
NASAL CAVITY AND PARANASAL SINUSES	UICC TNM 7

NASOPHARYNX	UICC TNM 7
NEUROBLASTOMA	INTERNATIONAL NEUROBLASTOMA STAGING SYSTEM
NON-HODGKINS LYMPHOMA (ADULT)	ANN-ARBOR
NON-HODGKINS LYMPHOMA (CHILDREN)	MURPHY ST. JUDE STAGING SYSTEM
OESOPHAGUS INCLUDING OESOPHAGOGASTRIC JUNCTION – CARCINOMA	UICC TNM 7
OESOPHAGUS INCLUDING OESOPHAGOGASTRIC JUNCTION – GIST	UICC TNM 7
ORAL CAVITY	UICC TNM 7
OROPHARYNX	UICC TNM 7
OMENTUM AND MESENTERY – GIST	UICC TNM 7
OVARY AND PERITONEUM	FIGO
PANCREAS	UICC TNM 7
PANCREAS - NEUROENDOCRINE TUMOURS	EUROPEAN NEUROENDOCRINE TUMOUR SOCIETY TNM***
PENIS	UICC TNM 6*
PLEURAL MESOTHELIOMA	UICC TNM 7*
PROSTATE	UICC TNM 7
RENAL PELVIS AND URETER	UICC TNM 7
RETINOBLASTOMA	UICC TNM 7
SARCOMA OF ORBIT	UICC TNM 7
SKIN - MALIGNANT MELANOMA	AJCC TNM 7
SKIN - MERKEL CELL CARCINOMA**	AJCC TNM 7
SKIN OF EYELID - CARCINOMA	UICC TNM 7
SMALL INTESTINE - GIST	UICC TNM 7
SMALL INTESTINE - NEUROENDOCRINE TUMOURS	EUROPEAN NEUROENDOCRINE TUMOUR SOCIETY TNM***
SMALL INTESTINE - CARCINOMA	UICC TNM 7
SOFT TISSUE	UICC TNM 7
STOMACH - CARCINOMA	UICC TNM 7
STOMACH – GIST	UICC TNM 7
STOMACH - NEUROENDOCRINE TUMOURS	EUROPEAN NEUROENDOCRINE TUMOUR SOCIETY TNM***
SUBGLOTTIS	UICC TNM 7
SUPRAGLOTTIS	UICC TNM 7
TESTIS	UICC TNM 7 & ROYAL MARSDEN STAGING SYSTEM*
THYROID	UICC TNM 7
UPPER AERODIGESTIVE TRACT - MALIGNANT MELANOMA	UICC TNM 7
URETHRA	UICC TNM 7
URINARY BLADDER	UICC TNM 7
UTERUS - ENDOMETRIUM	FIGO
UTERUS - UTERINE SARCOMA	FIGO
UVEA - MALIGNANT MELANOMA	UICC TNM 7
VAGINA	FIGO
VULVA	FIGO
VULVA – MALIGNANT MELANOMA	AJCC TNM 7

Note: the use of which preferred staging systems should be used is under frequent review, and are likely to change in the future.

* - These staging systems are recognised as currently being discussed and new guidance may be available soon.

** - Staging for merkel cell carcinoma of the skin has recently been added for collection in COSD if possible..

*** - See Section 0.10 Stage of COSD User Guide for advice on how to record for COSD

APPENDIX F – SKIN DATASET – AJCC STAGE GROUP ADDITIONAL INFORMATION

American Joint Committee on Cancer (AJCC) Additional Information

***AJCC STAGE GROUP** [AMERICAN JOINT COMMITTEE ON CANCER STAGE]: MELANOMA STAGING 7TH EDITION*

Clinical Staging[1]				**Pathological Staging[2]**			
AJCC stage Group	**T value**	**N value**	**M value**	**AJCC stage Group**	**T value**	**N value**	**M value**
Stage 0	Tis	N0	M0	Stage 0	Tis	N0	M0
Stage IA	T1a	N0	M0	Stage IA	T1a	N0	M0
Stage IB	T1b	N0	M0	Stage IB	T1b	N0	M0
	T2A	N0	M0		T2A	N0	M0
Stage IIA	T2b	N0	M0	Stage IIA	T2b	N0	M0
	T3a	N0	M0		T3a	N0	M0
Stage IIB	T3b	N0	M0	Stage IIB	T3b	N0	M0
	T4a	N0	M0		T4a	N0	M0
Stage IIC	T4b	N0	M0	Stage IIC	T4b	N0	M0
Stage III	Any T	≥N1	M0	Stage IIIA	T1-4a	N1a	M0
					T1-4a	N2a	M0
				IIIB	T1-4b	N1a	M0
					T1-4b	N2a	M0
					T1-4a	N1a	M0
					T1-4a	N2b	M0
					T1-4a	N2c	M0
				IIIC	T1-4b	N1b	M0
					T1-4b	N2b	M0
					T1-4b	N2c	M0
					Any T	N3	M0
Stage IV	Any T	Any N	M1	IV	Any T	Any N	M1

Notes

1 *Clinical staging includes microstaging of the primary melanoma and clinical/radiologic evaluation for metastases. By convention, it should be used after complete excision of the primary melanoma with clinical assessment for regional and distant metastases.*

2 *Pathologic staging includes microstaging of the primary melanoma and pathologic information about the regional lymph nodes after partial or complete lymphadenectomy. Pathologic Stage 0 or Stage IA patients are the exception; they do not require pathologic evaluation of their lymph nodes.*

3 *Histological measures of high risk differ between SCC and BCC and are fully covered by the RCPath data sets which are therefore recommended.*

AJCC STAGE GROUP ***[AMERICAN JOINT COMMITTEE ON CANCER STAGE]:NON-MELANOMA STAGING (BCC AND SCC) 7TH EDITION***

Stage	T	High risk features	N	M
0	Tis In situ			No distant metastases
I	T1 Tumor ≤2 cm in greatest dimension with <2 high-risk features	>2mm thickness Clarks level ≥ 4 Perineural invasion SCC site ear SCC site lip Poorly or un-differentiated	No Nodes	No distant metastases
II	T2 Tumor >2 cm in greatest dimension. or Tumor any size with ≥2 high-risk features	>2mm thickness Clarks level ≥ 4 Perineural invasion SCC site ear SCC site lip Poorly or un-differentiated	No Nodes	No distant metastases
III	T3 Tumor with invasion of maxilla, mandible, orbit, or temporal bone.		No Nodes	No distant metastases
III	T1, 2 or 3		Metastasis in a single ipsilateral lymph node, ≤3 cm in greatest dimension.	No distant metastases
IV	T1, T2 or T3		Metastasis in a single ipsilateral lymph node, >3 cm but ≤6 cm in greatest dimension; or in multiple ipsilateral lymph nodes, ≤6 cm in greatest dimension; or in bilateral or contralateral lymph nodes, ≤6	No distant metastases

			cm in greatest dimension.	
IV	Any T		Metastasis in a lymph node, >6 cm in greatest dimension.	No distant metastases
IV	Tumor with invasion of skeleton (axial or appendicular) or perineural invasion of skull base.		Any nodal status	No distant metastases
IV	Any tumour status		Any nodal status	Distant metastases

PRIMARY TUMOR (T)

TX Primary tumor cannot be assessed (for example, curettaged or severely regressed melanoma
T0 No evidence of primary tumor
Tis Melanoma in situ
T1 Melanomas 1.0 mm or less in thickness
T2 Melanomas 1.01–2.0 mm
T3 Melanomas 2.01–4.0 mm
T4 Melanomas more than 4.0 mm

Note: a and b subcategories of T are assigned based on ulceration and number of mitoses per mm2, as shown below:

THICKNESS CLASSIFICATION (mm)		**ULCERATION STATUS/MITOSES**
T1	≤1.0	a: w/o ulceration and mitosis <1/mm2
		b: with ulceration or mitoses ≥1/mm2
T2	1.01–2.0	a: w/o ulceration
		b: with ulceration
T3	2.01–4.0	a: w/o ulceration
		b: with ulceration
T4	>4.0	a: w/o ulceration
		b: with ulceration

REGIONAL LYMPH NODES (N)

NX Patients in whom the regional nodes cannot be assessed (for example, previously removed for another reason)

N0 No regional metastases detected

N1-3 Regional metastases based upon the number of metastatic nodes and presence or absence of intralymphatic metastases (in transit or satellite metastases)

NOTE: N1–3 and a–c subcategories assigned as shown below:

N OF CLASSIFICATION	**No of METASTATIC**	**NODES NODAL METASTATIC MASS**
N1	1 node	a: micrometastasis1

			b: macrometastasis2
N2	2–3 nodes	a: micrometastasis1	
			b: macrometastasis2
			c: in transit met(s)/satellite(s) *without* metastatic nodes
	N3		4 or more metastatic nodes, or matted nodes, or in transit met(s) /satellite(s) with metastatic node(s)

Distant Metastatis (M)

M0 No detectable evidence of distant metastases

M1a Metastases to skin, subcutaneous, or distant lymph nodes

M1b Metastases to lung

M1c Metastases to all other visceral sites or distant metastases to any site combined with an elevated serum LDH

NOTE: Serum LDH is incorporated into the M category as shown below:

M CLASSIFICATION	**SITE**	**SERUM LDH**
M1a	Distant skin, subcutaneous, or nodal mets	Normal
M1b	Lung metastases	Normal
M1c	All other visceral metastases	Normal
	Any distant metastasis	Elevated

Notes

1 *Micrometastases are diagnosed after sentinel lymph node biopsy and completion lymphadenectomy (if performed)*

2 *Macrometastases are defined as clinically detectable nodal metastases confirmed by therapeutic lymphadenectomy or when nodal metastasis exhibits gross extracapsular extension.*

APPENDIX G – TIMETABLE FOR IMPLEMENTATION

Minimum requirement for all Providers

<table>
<tr><th></th><th>July 2012 – Dec 2012</th><th>Jan 2013 – June 2013
PHASE 1</th><th>July 2013 – Dec 2013
PHASE 2</th><th>Jan 2014 – Dec 2014
PHASE 3</th><th>Jan 2015 onwards</th></tr>
<tr><td>CORE DATA ITEMS</td><td>Preparation including test downloads (voluntary basis)</td><td>Start CORE downloads</td><td rowspan="2">Continue CORE and SITE SPECIFIC STAGE downloads</td><td rowspan="3">Continue CORE and SITE SPECIFIC STAGE and SITE SPECIFIC CLINICAL downloads</td><td rowspan="4">Continue CORE and SITE SPECIFIC STAGE and SITE SPECIFIC CLINICAL and SITE SPECIFIC PATHOLOGY downloads (FULL COSD)</td></tr>
<tr><td>SITE SPECIFIC DATASETS - STAGE DATA ITEMS*</td><td>Preparation including test downloads (voluntary basis)</td><td>Start SITE SPECIFIC STAGE downloads</td></tr>
<tr><td>SITE SPECIFIC DATASETS - CLINICAL DATA ITEMS</td><td></td><td>Preparation including test downloads (voluntary basis)</td><td>Start SITE SPECIFIC CLINICAL downloads</td></tr>
<tr><td>SITE SPECIFIC DATASETS - PATHOLOGY DATA ITEMS</td><td></td><td></td><td>Preparation including test downloads (voluntary basis)</td><td>Start SITE SPECIFIC PATHOLOGY downloads</td></tr>
</table>

Additional requirement where currently collected electronically (optional)

<table>
<tr><th></th><th>July 2012 – Dec 2012</th><th>Jan 2013 – June 2013
PHASE 1</th><th>July 2013 – Dec 2013
PHASE 2</th><th>Jan 2014 – Dec 2014
PHASE 3</th><th>Jan 2015 onwards</th></tr>
<tr><td>SITE SPECIFIC CLINICAL DATA ITEMS</td><td>Preparation including test downloads (voluntary basis)</td><td>Start SITE SPECIFIC CLINICAL downloads (Items already collected)</td><td>Expand to full SITE SPECIFIC CLINICAL downloads</td><td>Continue CORE and SITE SPECIFIC STAGE and SITE SPECIFIC CLINICAL downloads</td><td>Continue CORE and SITE SPECIFIC STAGE and SITE SPECIFIC CLINICAL and SITE SPECIFIC PATHOLOGY downloads (FULL COSD)</td></tr>
<tr><td>SITE SPECIFIC PATHOLOGY DATA ITEMS</td><td>Preparation including test downloads (voluntary basis)</td><td>Start SITE SPECIFIC PATHOLOGY downloads (Items already collected)</td><td>Continue SITE SPECIFIC PATHOLOGY downloads (Items already collected)</td><td>Expand to full SITE SPECIFIC PATHOLOGY / Continue CORE and SITE SPECIFIC STAGE and SITE SPECIFIC CLINICAL downloads</td><td>Continue CORE and SITE SPECIFIC STAGE and SITE SPECIFIC CLINICAL and SITE SPECIFIC PATHOLOGY downloads (FULL COSD)</td></tr>
</table>

***SITE SPECIFIC STAGE ITEMS TO BE SUBMITTED FROM START OF IMPLEMENTATION**

COLORECTAL - modified Dukes
CTYA - Murphy (St Jude) Stage, Ann Arbor Stage, Ann Arbor Symptoms, Ann Arbor Extranodality, International neuroblastoma staging system, Wilms tumour stage, TNM stage grouping for Non CNS Germ Cell Tumours, Chang staging for medulloblastoma
GYNAE - Final FIGO stage, Nodal status cervical cancer
HAEMATOLOGY, Rai stage, Binet stage, ISS stage for Myeloma, Ann Arbor Stage, Ann Arbor Symptoms, Ann Arbor Extranodality, Ann Arbor Bulk
SKIN - AJCC Stage group
UROLOGY - Stage group (Testicular)

APPENDIX H – WHEN TO COMPLETE AND SUBMIT THE DATA

The following table shows the point in the pathway (event) when the different sections of the dataset are expected to be completed and submitted. Once the relevant Pathway Event ("Trigger") has occurred, the related field (see Key to Pathway Events) should be completed along with other applicable data items in the sections noted. Data items marked as Mandatory in the relevant section of the dataset must be submitted for the record to pass validation rules. Items marked Required should be submitted where applicable and as soon as possible after the initial record is uploaded. Once the trigger event has occurred the record should be sent in the next submission (25 working days after month end). Every effort should be made to complete all the applicable items in that section before submission where possible. Any missing items should ideally be completed and submitted within three months of diagnosis (or of subsequent treatment), however the final deadline for completion of relevant items is six months after month of diagnosis (or subsequent treatment).

(Although the final deadline for completion of relevant items is six months after month of diagnosis (or subsequent treatment), the English National Cancer Registration Service follows principles and procedures defined internationally, which advise that registrations are obtained from a variety of multiple sources and can be updated continuously and in a systematic manner (IARC, 1991). For this reason, any information made available to the Cancer Registration Service will always be used to update a record even if this is made after the date that a registration is declared complete for analytical purposes or for submission to ONS).

KEY ●Must be submitted for this event OShould be submitted for this event if available/applicable #CORE LINKAGE: IF ANY OF THESES ITEMS CHANGE AFTER SUBMISSION, CONTACT THE REGISTRY	PATHWAY EVENT ("TRIGGER")										
SECTION	NEW DIAGNOSIS*	FIRST TREATMENT**	SUBSEQUENT TREATMENT**	TERTIARY REFERRAL*	TERTIARY FIRST TREATMENT**	TERTIARY SUBSEQUENT TREATMENT**	RECURRENCE – NEW DIAGNOSIS***	RECURRENCE – TREATMENT**	REC' – TTERTI'Y REFERRAL***	REC' – TTERTI'Y TREATMENT**	ANY OTHER DATA CHANGES
CORE - LINKAGE (Patient Identity and Diagnostic Details)#	●	●	●	●	●	●	●	●	●	●	#
CORE - DEMOGRAPHICS	●			●			●		●		O
CORE - REFERRALS AND FIRST STAGE OF PATIENT PATHWAY	●										O
CORE – IMAGING (pre treatment)	O			O			O		O		O
CORE - PATHOLOGY DETAILS (Pre treatment, eg biopsies)	●			O			O		O		O
CORE - DIAGNOSIS	●			O			●		O		O
CORE - CANCER CARE PLAN	O			O			●		O		O
CORE - CLINICAL TRIALS	O		O	O		O					O
CORE – STAGING (Pre treatment)	●			O							O
CORE - TREATMENT		●	●		●	●		●		●	O
CORE - SURGERY AND OTHER PROCEDURES		O	O		O	O		O		O	O
CORE - RADIOTHERAPY		O	O		O	O		O		O	O
CORE - ACTIVE MONITORING		O			O			O		O	O
CORE - PATHOLOGY DETAILS (Post treatment, eg resection)		O	O		O	O		O		O	O
CORE – STAGING (Post treatment)		●			O					O	O
CORE – IMAGING (post treatment)		●	O		●	O		O		O	O
CORE - DEATH DETAILS	O	O	O	O	O	O	O	O	O	O	O
CORE - CANCER RECURRENCE / SECONDARY CANCER							●	O	●	O	O

KEY TO PATHWAY EVENTS ("TRIGGER" DATA ITEMS)
* NEW DIAGNOSIS = DATE OF DIAGNOSIS (CLINICALLY AGREED)
** TREATMENT = TREATMENT START DATE (CANCER)
***RECURRENCE DIAGNOSIS = DATE OF RECURRENCE (CLINICALLY AGREED)
#CORE LINKAGE: IF ANY OF THESES ITEMS CHANGE AFTER SUBMISSION, CONTACT THE REGISTRY

There is no requirement to combine data fields extracted from different systems prior to submission. Extracts may be uploaded from different systems as long as the linkage items are included for each record and the

schema rules for Mandatory items in each section are adhered to. (Any problems with this should be discussed with the National Cancer Registration Service receiving the extracts)

APPENDIX I – PATIENTS DIAGNOSED PRIOR TO 2013

Additional information on Scenarios for patients diagnosed prior to Jan 2013

For patients with a diagnosis before 1st Jan 2013 the COSD is not applicable. Providers should aim to complete the registration dataset for these patients by end of February 2013.

Scenario 1. Patient diagnosed with Cancer pre Jan 2013 receiving first treatment for this primary cancer after Jan 1st 2013.
COSD is not applicable.
Cancer Waiting Times record to be completed as per NCWTMDS guidance.
All other cancer datasets to be completed in accordance with specific guidance (eg SACT for patients treated with Chemotherapy, RTDS for patient treated with Radiotherapy)

Scenario 2. Patient diagnosed with Cancer pre Jan 2013 receiving subsequent treatment for this primary cancer after Jan 1st 2013.
COSD is not applicable.
Cancer Waiting Times record to be completed as per NCWTMDS guidance.
All other cancer datasets to be completed in accordance with specific guidance (eg SACT for patients treated with Chemotherapy, RTDS for patient treated with Radiotherapy)

Scenario 3. Patient diagnosed with Cancer pre Jan 2013. Diagnosed with a different cancer after 1st Jan 2013.
COSD is applicable for the new cancer and relevant site specific and core data items should be completed.
Cancer Waiting Times record to be completed if applicable as per NCWTMDS guidance.
All other cancer datasets to be completed in accordance with specific guidance (eg SACT for patients treated with Chemotherapy, RTDS for patient treated with Radiotherapy)

Scenario 4. Patient diagnosed with Cancer pre Jan 2013. Diagnosed with a recurrence of this cancer after 1st Jan 2013.
COSD is applicable for the recurrence.
Cancer Waiting Times record to be completed if applicable as per NCWTMDS guidance.
All other cancer datasets to be completed in accordance with specific guidance (eg SACT for patients treated with Chemotherapy, RTDS for patient treated with Radiotherapy)

APPENDIX J – REFERRAL SCENARIOS

Referral information is required once for each cancer diagnosis and is completed by the Provider which diagnosed the cancer. This should therefore be recorded from the beginning of the referral pathway within the Provider which led to the cancer diagnosis. It will normally begin at the referral to outpatients from primary care, from emergency services or from another Provider.
Cancer Waiting Times only requires this information for 2ww and screening referrals but for COSD it is essential that details of the referral section of the pathway are recorded for all cases.

Data items from Referral to First Seen Date

The following data items should be completed according to the scenarios following:

PRIORITY TYPE CODE
SOURCE OF REFERRAL FOR OUTPATIENTS
DATE FIRST SEEN
CONSULTANT CODE
ORGANISATION CODE (PROVIDER FIRST SEEN)

SCENARIOS

SCENARIO 1:. 2 WEEK WAIT AND SCREENING CASES –details as covered by Cancer Waiting Times guidance

SCENARIO 2: PATIENTS INITIALLY REFERRED TO OUTPATIENTS:

SOURCE OF REFERRAL FOR OUT-PATIENTS will normally be

03	referral from a GENERAL MEDICAL PRACTITIONER
92	referral from a GENERAL DENTAL PRACTITIONER
12	referral from a GENERAL PRACTITIONER with Special Interest

Or if referred from another Hospital

05	referral from a CONSULTANT, other than in an Accident And Emergency Department

Other referral sources listed may also be applicable

SCENARIO 3: PATIENTS INITIALLY SEEN AS EMERGENCIES BUT THEN REFERRED TO ANOTHER CONSULTANT:

SOURCE OF REFERRAL FOR OUT-PATIENTS will be either:

01	following an emergency admission
10	following an Accident And Emergency Attendance (including Minor Injuries Units and Walk In Centres)
04	referral from an Accident And Emergency Department (including Minor Injuries Units and Walk In Centres)

DATE FIRST SEEN will be the first outpatient appointment following the emergency presentation or the first consultation with the specialist if patient remained as an inpatient.
CONSULTANT CODE relates to Date First Seen so will be the consultant who the patient was referred to following the emergency presentation.
ORGANISATION CODE (PROVIDER FIRST SEEN) relates to the Date First Seen so will be the organisation the patient was referred to following the emergency presentation.

SCENARIO 4: PATIENTS WHERE CANCER WAS INITIALLY DIAGNOSED AND FIRST TREATED AS AN EMERGENCY:

SOURCE OF REFERRAL FOR OUT-PATIENTS will normally be one of the emergency codes above
DATE FIRST SEEN will be the date of the emergency first treatment
CONSULTANT CODE relates to Date First Seen so will be the consultant carrying out the first treatment
ORGANISATION CODE (PROVIDER FIRST SEEN) relates to the Date First Seen so will be the organisation carrying out the first treatment

SCENARIO 5: PATIENTS WHERE CANCER WAS AN INCIDENTAL FINDING OF ANOTHER TREATMENT OR PROCESS

SOURCE OF REFERRAL FOR OUT-PATIENTS will be

11	other - initiated by the CONSULTANT responsible for the Consultant Out-Patient Episode

DATE FIRST SEEN will be the date of the incidental finding
CONSULTANT CODE relates to Date First Seen so will be the consultant who made the incidental findings during another treatment or process
ORGANISATION CODE (PROVIDER FIRST SEEN) relates to the Date First Seen so will be the organisation where the incidental findings were made

Data items for Cancer Specialist

The following data items should be completed according to the scenarios following:

FIRST SEEN BY SPECIALIST DATE (CANCER)
ORGANISATION CODE (PROVIDER FIRST CANCER SPECIALIST)

SCENARIO 1: PATIENT WAS FIRST SEEN BY THE APPROPRIATE CANCER SPECIALIST
Use same details as DATE FIRST SEEN and ORGANISATION CODE (PROVIDER FIRST SEEN)

SCENARIO 2: INITIAL REFERRAL WAS NOT TO THE APPROPRIATE CANCER SPECIALIST
Record details for the first appointment with the appropriate cancer specialist to progress this cancer diagnosis.

APPENDIX K – DATA ITEMS FROM OTHER STANDARDS (FOR REFERENCE)

	CORE - REFERRALS AND FIRST STAGE OF PATIENT PATHWAY To carry patient referral details to the Provider that receives the first referral.					
CR1380	CORE - REFERRALS	**PATIENT PATHWAY IDENTIFIER**		PATIENT PATHWAY IDENTIFIER	CWT	X
CR1390	CORE - REFERRALS	**ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)**		SITE CODE (PATIENT PATHWAY IDENTIFIER ISSUER)	CWT	X
CR0260	CORE - REFERRALS	**TWO WEEK WAIT CANCER OR SYMPTOMATIC BREAST REFERRAL TYPE**		TWO WEEK WAIT CANCER OR SYMPTOMATIC BREAST REFERRAL TYPE	CWT	X
CR0190	CORE - REFERRALS	**DECISION TO REFER DATE (CANCER OR BREAST SYMPTOMS)**		DECISION TO REFER DATE (CANCER OR BREAST SYMPTOMS)	CWT	X
CR2020	CORE - REFERRALS	**PRIORITY TYPE CODE**		PRIORITY TYPE CODE	CWT	X
CR0200	CORE - REFERRALS	**CANCER REFERRAL TO TREATMENT PERIOD START DATE**		CANCER REFERRAL TO TREATMENT PERIOD START DATE	CWT	X
CR1620	CORE - REFERRALS	**CONSULTANT UPGRADE DATE**		CONSULTANT UPGRADE DATE	CWT	X
CR3010	CORE - REFERRALS	**ORGANISATION SITE CODE (PROVIDER CONSULTANT UPGRADE)**		SITE CODE (OF PROVIDER CONSULTANT UPGRADE)	CWT	X
CR0280	CORE - REFERRALS	**WAITING TIME ADJUSTMENT (FIRST SEEN)**		WAITING TIME ADJUSTMENT (FIRST SEEN)	CWT	X
CR0290	CORE - REFERRALS	**WAITING TIME ADJUSTMENT REASON (FIRST SEEN)**		WAITING TIME ADJUSTMENT REASON (FIRST SEEN)	CWT	X
CR0250	CORE - REFERRALS	**DELAY REASON COMMENT (FIRST SEEN)**		DELAY REASON COMMENT (FIRST SEEN)	CWT	X
CR0240	CORE - REFERRALS	**DELAY REASON REFERRAL TO FIRST SEEN (CANCER OR BREAST SYMPTOMS)**		DELAY REASON REFERRAL TO FIRST SEEN (CANCER OR BREAST SYMPTOMS)	CWT	X
	CORE - TREATMENT To carry cancer treatment details.					
CR1420	CORE - TREATMENT	**ORGANISATION SITE CODE (PROVIDER DECISION TO TREAT CANCER)**		ORGANISATION CODE (PROVIDER DECISION TO TREAT CANCER)	CWT	X
CR1430	CORE - TREATMENT	**CANCER TREATMENT PERIOD START DATE**		CANCER TREATMENT PERIOD START DATE	CWT	X
CR1440	CORE - TREATMENT	**CANCER CARE SETTING (TREATMENT)**		CANCER CARE SETTING (TREATMENT)	CWT	X
CR1460	CORE - TREATMENT	**DELAY REASON COMMENT (DECISION TO TREATMENT)**		DELAY REASON COMMENT (DECISION TO TREATMENT)	CWT	X
CR1470	CORE - TREATMENT	**DELAY REASON (DECISION TO TREATMENT)**		DELAY REASON (DECISION TO TREATMENT)	CWT	X

CR1480	CORE - TREATMENT	**WAITING TIME ADJUSTMENT (TREATMENT)**		WAITING TIME ADJUSTMENT (TREATMENT)	CWT	X
CR1490	CORE - TREATMENT	**WAITING TIME ADJUSTMENT REASON (TREATMENT)**		WAITING TIME ADJUSTMENT REASON (TREATMENT)	CWT	X
CR1500	CORE - TREATMENT	**DELAY REASON COMMENT (REFERRAL TO TREATMENT)**		DELAY REASON COMMENT (REFERRAL TO TREATMENT)	CWT	X
CR1510	CORE - TREATMENT	**DELAY REASON REFERRAL TO TREATMENT (CANCER)**		DELAY REASON REFERRAL TO TREATMENT (CANCER)	CWT	X
CR1520	CORE - TREATMENT	**DELAY REASON COMMENT (CONSULTANT UPGRADE)**		DELAY REASON COMMENT (CONSULTANT UPGRADE)	CWT	X
CR1530	CORE - TREATMENT	**DELAY REASON (CONSULTANT UPGRADE)**		DELAY REASON (CONSULTANT UPGRADE)	CWT	X
CR1250	CORE - TREATMENT	**CLINICAL TRIAL INDICATOR**		CLINICAL TRIAL INDICATOR	CWT	X
	CORE - RADIOTHERAPY To carry the radiotherapy details. A course of radiotherapy is defined as a string of prescriptions which are consecutive.					
CR1560	CORE - RADIOTHERAPY	**RADIOTHERAPY PRIORITY**		RADIOTHERAPY PRIORITY	CWT / RDTS	X
CR1570	CORE - RADIOTHERAPY	**RADIOTHERAPY INTENT**		RADIOTHERAPY INTENT	CWT	X
CR1140	CORE - RADIOTHERAPY	**ANATOMICAL TREATMENT SITE (RADIOTHERAPY)**		ANATOMICAL TREATMENT SITE (RADIOTHERAPY)	RDTS	X
	CORE - CHEMOTHERAPY AND OTHER DRUGS To carry the details of chemotherapy and/or other anti- ancer and/or supportive drugs given to the patient during their treatment. One occurrence of this data group is permitted per treatment where applicable.					
CR1070	CORE - CHEMOTHERAPY AND OTHER DRUGS	**DRUG TREATMENT INTENT**		DRUG TREATMENT INTENT	SACT	X
CR1080	CORE - CHEMOTHERAPY AND OTHER DRUGS	**DRUG REGIMEN ACRONYM**		DRUG REGIMEN ACRONYM	SACT	X

APPENDIX L – DATA ITEMS FROM OTHER SOURCES (FOR REFERENCE)

Data item No.	Data Item Section	Data Item Name	Format	Data Dictionary Element	Current Collection	Schema Specification
	CORE - DEMOGRAPHICS To carry the patient demographic details. It is anticipated that some of the demographic data items listed below will be collected by every provider with which the patient has contact. Where this information is exchanged, the appropriate data item name should be used to identify the particular instance of the data. One occurrence of this group is permitted					
CR3080	CORE - DEMOGRAPHICS	**ORGANISATION CODE (GP PRACTICE RESPONSIBILITY)**	an3	ORGANISATION CODE (GP PRACTICE RESPONSIBILITY)	NEW	X
CR3090	CORE - DEMOGRAPHICS	**ORGANISATION CODE (RESIDENCE RESPONSIBILITY)**	an3	ORGANISATION CODE (RESIDENCE RESPONSIBILITY)	NEW	X
	CORE - DIAGNOSIS To carry diagnosis details. One occurrence of this group is permitted					
CR0360	CORE - DIAGNOSIS	**DATE OF DIAGNOSIS (CANCER REGISTRATION)**	an10 ccyy-mm-dd	DATE OF DIAGNOSIS (CANCER REGISTRATION)	CANCER REGISTRY	X

CR0170	CORE - DIAGNOSIS	**DATE OF RECURRENCE (CANCER REGISTRATION)**	an10 ccyy-mm-dd	DATE OF RECURRENCE (CANCER REGISTRATION)	NEW	X
	CORE - RADIOTHERAPY DETAILS To carry the death details (not required for direct submission by Trusts) One occurrence of this group is permitted per treatment where applicable.					
CR2080	CORE - RADIOTHERAPY	**RADIOTHERAPY TOTAL DOSE**	max n3.n2	RADIOTHERAPY TOTAL DOSE	RTDS	
CR2090	CORE - RADIOTHERAPY	**RADIOTHERAPY TOTAL FRACTIONS**	max n2	RADIOTHERAPY TOTAL FRACTIONS	RTDS	X
						X
	CORE - DEATH DETAILS To carry the death details (not required for direct submission by Trusts) One occurrence of this group is permitted					
CR1270	CORE - DEATH DETAILS	**PERSON DEATH DATE**	an10 ccyy-mm-dd	PERSON DEATH DATE	ONS	
CR1280	CORE - DEATH DETAILS	**DEATH LOCATION TYPE**	an1	DEATH LOCATION TYPE	ONS	X
CR3020	CORE - DEATH DETAILS	**DEATH CAUSE IDENTIFICATION METHOD**	an1	DEATH CAUSE IDENTIFICATION METHOD	ONS	X
CR1300	CORE - DEATH DETAILS	**DEATH CAUSE ICD CODE (IMMEDIATE)**	an6	DEATH CAUSE ICD CODE (IMMEDIATE)	ONS	X
CR1310	CORE - DEATH DETAILS	**DEATH CAUSE ICD CODE (CONDITION)**	an6	DEATH CAUSE ICD CODE (IMMEDIATE)	ONS	X

CR1320	CORE - DEATH DETAILS	**DEATH CAUSE ICD CODE (UNDERLYING)**	an6	DEATH CAUSE ICD CODE (UNDERLYING)	ONS	X
CR1330	CORE - DEATH DETAILS	**DEATH CAUSE ICD CODE (SIGNIFICANT)**	an6	DEATH CAUSE ICD CODE (SIGNIFICANT)	ONS	X
						X
	BREAST - REFERRALS To carry referral details for breast cancer One occurrence of this group is permitted					
BR4025	BREAST - REFERRALS	**SCREENING STATUS FOR CANCER**	an1	CANCER SCREENING STATUS	SCREENING	
						X
	GYNAECOLOGY - REFERRAL To carry referral details for gynae cancer One occurrence of this group is permitted					
GY7030	GYNAECOLOGY - REFERRAL	**SCREENING STATUS FOR CANCER**	an1	CANCER SCREENING STATUS	SCREENING	
						X
	COLORECTAL - REFERRALS To carry referral details for colorectal cancer One occurrence of this group is permitted					

CO5000	COLORECTAL - REFERRALS	**SCREENING STATUS FOR CANCER**	an1	CANCER SCREENING STATUS	SCREENING

APPENDIX M – UNDERSTANDING CANCER ONLINE E-LEARNING TRAINING

Institute of Healthcare Management

Understanding Cancer

Oncology Training for NHS and Public Health non-clinical staff

Professionally Accredited by the Institute of Healthcare Management

Launch date: 2 April 2012

Key features include:

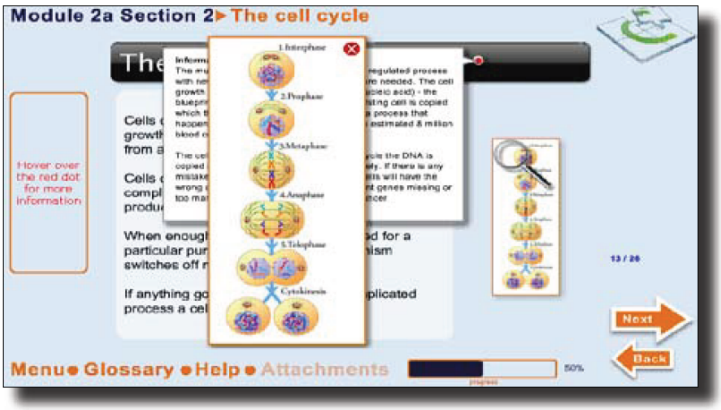
- flexibility to work at your own pace from work or home
- ability to stop and resume at any point from any computer
- reference guides
- colourful images throughout
- glossary of terms
- learning objectives
- quizzes
- certificate of achievement

Who it is for and what you will learn

This new e-learning tool is aimed primarily at **Multi-disciplinary Team Co-ordinators** and **Cancer Registration staff** who need to know:

- about cancer–medical terminology, diagnostic tests and treatments
- how cancer services are organised in the NHS
- about cancer types–key risks, including causes, risk factors, signs and symptoms, anatomy and physiology

Other NHS staff can also use it to improve their understanding of cancer



What to do next

For more information, visit www.ncin.org.uk. You will be able to self register onto the learning space website ready for the launch on the 2nd April 2012

EastMidlands Cancer Network Unlocking better care · NCIN national cancer intelligence network · ukacr United Kingdom Association of Cancer Registries · National Cancer Action Team Part of the National Cancer Programme · NHS

http://www.ncin.org.uk/cancer_information_tools/training/default.aspx

APPENDIX N – A STATEMENT REGARDING THE USE OF M0 AND MX IN THE STAGING OF CANCERS

Background

TNM editions prior to TNM7 included the category MX to identify when distant metastases could not be assessed. TNM7 removed this category, because the overuse of the MX category meant that a large proportion of tumours was not staged (a TNM group stage cannot be applied if MX is used).

According to the rules of TNM7, M0 should be used if there is no positive evidence of distant metastases. However, clinical practice in the UK has persisted in using the MX category.

The National Staging Panel for Cancer Registration wishes to propose a modification to TNM7 to be used in England and retain the use of MX in specific circumstances.

When can MX be used?

MX may be used in the pretreatment or integrated stage when in normal circumstances further investigations would be deemed necessary to exclude distant metastases but these are not performed because either the patient has declined further investigation or the patient has co-morbidities that preclude staging investigations or the prognosis and treatment would be unaffected by further knowledge about distant metastases.

MX may also be used in radiological reports where the radiologist wishes to indicate that they have been unable to assess, or have no information about distant metastases.

Pathologists are typically unable to comment on the status of distant metastases if the specimen does not include appropriate material. In such circumstances, it is appropriate for MX to be recorded.

When should MX not be used?

MX should not be used in either the pretreatment or integrated stage when there is no evidence of distant metastatic disease and further investigations to look for metastatic disease are deemed inappropriate because the clinical risk is low. For example, a patient with small breast tumour without nodal metastases (T1/T2 N0) is clinically unlikely to have distant metastatic disease and will not routinely have cross-sectional imaging. Such patients are considered to have been clinically assessed as cM0 and therefore M0 should be recorded in both the pretreatment and integrated stage fields.

MX must not be used as a default entry and must only be selected in the specific circumstances highlighted above.

Can the M stage just be left blank (M9 in COSD)?

The M stage should only be left blank when the result of investigations is not known – for example the patient has been diagnosed at Trust A but has their care transferred to Trust B for further investigations. Trust A may legitimately leave the M stage blank if they have not received notification about the outcome of the investigations. For the purposes of recording data within the Cancer Outcomes Dataset (COSD), M9 should be recorded in these circumstances to signify that M is intentionally being left blank. Please note however in these circumstances, Trust B would be expected to provide additional data about M stage.

Does the use of MX or M9 affect assigning a Stage Grouping?

Providers will not be able to provide a Stage Grouping when MX or M9 are used.

What should be recorded if the status of distant metastatic disease is uncertain because of indeterminate findings?

If the status of distant metastatic disease is indeterminate because interpretation of the clinical findings is uncertain (for example a CT scan shows a liver lesion and the radiologist/MDT is uncertain if it represents metastatic disease or a benign lesion) then the TNM principle of applying the lower category should be used and M0 should be recorded.

What if an indeterminate lesion is later identified to be malignant?

Indeterminate lesions are often monitored by repeated imaging and can be identified as malignant if their characteristics change over time. If such lesions are identified as malignant before the initiation of treatment, both the pretreatment and integrated stage should be recorded as M1.

If such lesions are identified as malignant after the initiation of treatment, the pretreatment stage should be recorded as M0 (as this reflects the decision making process that determined the treatment). The integrated stage however should be recorded as M1.

How will the cancer registries handle MX and will this hinder international comparisons of data?

It is important that data collected in the UK can be compared with international performance data. If the Registry has received MDT data that include MX, the Registry may convert this to M0 when the data is to be used for international comparison. This will allow robust international comparison. It is important to note that Registry will only be able to do this when MX has been specifically selected in the integrated and or pretreatment stage submitted by the MD T. M9 will not be converted to M0 by the cancer registries.

Does the same logic apply to T and N components too?

TX and NX are still allowed in TNM7, so the issues are not the same as for the M component. However, the categories T9 and N9 will be added to COSD so that the definitions of X and 9 are consistent across the definitions. So, for each of the T, N and M components X should be a clinical decision that the component cannot be assessed and 9 should be used in COSD submissions to indicate that the data is not available.

Author: National Staging Panel for Cancer Registration Last updated: 18/01/2013